

CHAPTER 879

AN ACT in relation to the public health, constituting chapter
forty-five of the consolidated laws

Became a law April 20, 1953, with the approval of the Governor. Passed,
by a majority vote, three-fifths being present

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

CHAPTER 45 OF THE CONSOLIDATED LAWS

PUBLIC HEALTH LAW

Article

1. Short title and definitions: general provisions

Title I. Short title and definitions (§§ 1-2).

II. General provisions (§§ 10-24).

III. Office of the medicaid inspector general (§§
30-36).

2. The department of health.

Title I. Officers and employees (§§ 200--211-a).

II. The public health council (§§ 220-229).

II-A. Professional medical conduct (§§ 230--230-e).

* II-B. New York state health services corps (§§
231-233).

* NB Expired July 18, 1996

II-C. Charles D. Cook office of rural health (§§
234-237).

II-D. Health care practitioner referrals (§§
238--238-e).

II-E. HIV/HBV/HCV prevention training (§§
239--239-b).

II-F. Office of minority health (§§ 240*-244*).

III. State health areas (§§ 240-243).

IV. Spinal cord injury research board (§§ 250-251).

V. Health care practitioner volunteer pilot
program (§ 260).

V*. Obesity prevention act (§§ 260*-263).

VI. Women's Health (§§ 266-268).

6-A. The 21st century workgroup for disease
elimination and reduction (§ 266-a).

- VII. NY State of Health (§§ 268-268-h).
 - 8. Hunger prevention and nutrition assistance program (§ 269).
- 2-A. Prescription drugs.
 - Title I. Preferred drug and clinical drug review programs (§§ 270-277).
 - II. Prescription drugs; various provisions (§§ 278--280-d).
 - III. Prescription forms, electronic prescribing and language assistance (§ 281).
- 2-B. Drug take back (§§ 290-294).
- 3. Local health organization.
 - Title I. Local boards of health; general provisions (§§ 300-312).
 - II. Local health officers (§§ 320-329).
 - III. County and part-county health districts (§§ 340-357).
 - IV. Certain cities (§§ 360-378).
 - V. State park health districts (§§ 380-383).
 - VI. Consolidated health districts (§§ 390-399).
- 4. Property and hospitals in the department of health
 - Title I. General provisions (§§ 401-410).
 - II. Hospitals; boards of visitors (§§ 420-425).
 - IV. Hospitals; officers and employees (§§ 450-455).
- 4-A. Regulation of body piercing and tattooing (§§ 460-467).
- 4-B. Tongue-splitting (§ 470).
- 5. Laboratories
 - Title I. General provisions: state laboratories; approved laboratories (§§ 500-506).
 - II. County laboratories (§§ 520-528).
 - III. City laboratories (§§ 540-545).
 - IV. Laboratory supply stations (§§ 560-563).
 - V. Clinical laboratory and blood banking services (§§ 570-581).
 - VI. Laboratory business practices (§§ 585-588).
- 6. State aid to cities and counties
 - Title I. State aid for basic services (§§ 600-607).

- II. State aid for additional services (§§ 608-613).
- III. State aid; general provisions (§§ 614-621).
- 6-A. Rape crisis intervention and prevention program (§§ 695--695-e).
- 7. Federal grants-in-aid (§§ 700-703).
- 8. State health research council (§§ 800-803).
- 9. Primary care education and training (§§ 900-907).
- 9-A. New York state small business health insurance partnership program (§§ 921-922).
- 9-B. Primary Care Service Corps Practitioner Loan Repayment Program (§§ 923-924).
- 11. Public water supplies; sewerage and sewage control
 - Title I. Potable waters (§§ 1100--1114-b).
 - II. Realty subdivisions: water supply (§§ 1115-1120).
 - II-A. Water supply emergency plans (§ 1125).
 - III. Annual water supply statement (§§ 1150-1153).
 - IV. Drinking water revolving fund (§§ 1160-1169).
- 13. Nuisances and sanitation
 - Title I. General provisions: control and abatement (§§ 1300-1310).
 - II. Noxious weeds and growths (§§ 1320-1321).
 - III. Tenement house sanitation (§ 1325).
 - IV. Labor camp sanitation (§ 1330).
 - V. Suppression of certain businesses (§§ 1335-1336).
 - VI. Bathing establishments (§§ 1340-1342).
 - VII. Hotel sanitation (§§ 1345-1348).
 - VIII. Food handling (§§ 1350-1357).
 - IX. Location and disposition of radioactive gold jewelry (§ 1360).
 - X. Control of lead poisoning (§§ 1370-1377).
 - XI. State aid; planning for construction of solid waste management facilities (§§ 1380-1383).
 - XII. Toxic substances (§§ 1385-1389).
 - XII-A. Inactive hazardous waste disposal sites (§§1389-a--1389-e).

XIII. Storage, treatment and disposal of infectious waste (§§ 1389-aa--1389-gg).

- 13-A. State camp safety advisory council (§ 1390).
- 13-B. Regulation of overnight, summer day, and traveling summer day camps for children (§§ 1391-1396).
- 13-D. Regulation of housing; used as accommodations by employees of certain motels and hotels (§§ 1399-j--1399-m).
- 13-E. Regulation of smoking and vaping in certain public areas (§§ 1399-n--1399-x).
- 13-F. Regulation of tobacco products and herbal cigarettes; distribution to minors (§§ 1399-aa--1399-mmm).
- 13-G. Tobacco escrow funds (§§ 1399-nn--1399-pp).
- 13-H. Regulation of sharps (§§ 1399-ss--1399-ww).
- 13-I. Regulation of supplements and other products; distribution to minors (§ 1399-xx).
- 14. Regulation of camps for children (§§ 1400-1408).
- 15. Insect control
 - Title I. Municipal insect control (§§ 1500-1503).
 - II. County insect control (§§ 1520-1531).
- 16. Pesticide control board (§§ 1601-1609).
- 17. Ingredient disclosures for vapor products and e-cigarettes (§§ 1700-1702).
- 20. Reporting of Alzheimer's Disease (§§ 2000--2004-a).
- 20-A. Alzheimer's Community Assistance Program (§§ 2005-2009).
- 20-B. State Parkinson's disease registry (§§ 2010-2014).
- 20-C. State Frontotemporal Degeneration registry (§§ 2015-2019).
- 20-C*2. State Amyotrophic Lateral Sclerosis and Motor Neuron Disease registry (§§ 2020-2024).
- 21. Control of acute communicable diseases
 - Title I. General provisions (§§ 2100-2112).
 - II. Control of patients (§§ 2120-2125).
 - III. Human immunodeficiency virus (§§ 2130-2139).
 - IV. Rabies (§§ 2140-2146).
 - V. Typhoid fever (§§ 2150-2153).
 - VI. Poliomyelitis and Other Diseases (§§ 2160-2169).
 - VII. Hepatitis C (§§ 2170-2171).

- 8. Novel coronavirus, COVID-19 (§§ 2180-2183).
- 21-A. Long-term care resident and employee immunization act (§§ 2190-2196).
- 22. Control of tuberculosis
 - Title I. General provisions (§§ 2200-2207).
 - II. Control (§§ 2221-2230).
- 23. Control of sexually transmissible diseases
 - Title I. Care and treatment (§§ 2300-2312).
 - II. Houses of prostitution: injunction and abatement (§§ 2320-2334).
- 24. Control of malignant diseases
 - Title I. General provisions (§§ 2400--2404-d).
 - Title I-A. Cancer Detection and Education Program (§§ 2405--2409-a).
 - Title I-B. Health Research Science Board (§§ 2410-2413).
 - II. State institute for the study of malignant diseases (§§ 2420-2423).
- 24-A. Protection of human subjects (§§ 2440-2446).
- 24-B. Information program on dioxin (§ 2475).
- 24-C. Information program on low-level radioactive waste (§ 2485).
- 24-D. New York state occupational health clinics oversight committee (§§ 2490--2490-a).
- 24-E. Information about hysterectomy (§§ 2495--2499-a).
- 25. Maternal and child health
 - Title I. General provisions (§§ 2500--2509-d).
 - I-A. Child health insurance plan (§§ 2510-2511).
 - 1-B. Adolescent pregnancy prevention and services program (§§ 2515-2515-c).
 - II. Prenatal care (§§ 2522-2532).
 - II-A. Early intervention program for infants and toddlers with disabilities and their families (§§ 2540--2559-b).
 - IV. Institutions for children (§§ 2570-2575).
 - V. Children with physical disabilities (§§ 2580-2584).
 - VI*. Federal child care and adult food program (§§ 2585-2589).

* VI. Emergency nutrition aid program for pregnant women and adolescents (§§ 2590-2592)

* NB Expired March 31, 1986

VII. Youth sports (§ 2595).

VIII. Childhood obesity prevention program (§§ 2599-a--2599-d).

25-A. Reproductive health act (§§ 2599-aa--2599-bb).

25-B. Gestational surrogacy (§ 2599-cc).

26. Helen Hayes Hospital (§§ 2600-2602).

26-A. New York state veterans' home (§§ 2630-2635).

27. Bureau of chronic disease and geriatrics (§§ 2700-2702).

27-A. Osteoporosis prevention and education (§§ 2705-2706).

27-AA. New York state kidney disease institute (§§ 2710-2712).

27-B. Treatment of hypertension.

Title I. Mary Lasker Heart and Hypertension Institute (§§ 2720-2722).

II. Centers for the treatment of hypertension (§§ 2723-2724).

27-C. Birth defects institute (§§ 2730-2733).

27-CC. New York state traumatic brain injury program (§§ 2740-2744).

27-CCC. Leukemia, lymphoma and myeloma research, education and treatment program (§ 2747).

27-D. New York state burns care institute (§§ 2750-2752).

27-DD. State advisory panel on HIV/HBV infected health care workers (§§ 2760-2761).

27-E. The acquired immune deficiency syndrome institute (§§ 2775-2779).

27-F. HIV and AIDS related information (§§ 2780-2787).

27-G. Adult cystic fibrosis assistance program (§ 2795).

27-H*. Diabetes research and education program (§ 2796).

27-H. The Tick-Borne Disease Institute (§§ 2797--2798).

27-K. New York Wellness Works (§§ 2799-o--2799-r).

28. Hospitals (§§ 2800--2832-a).

28-A. Nursing home companies (§§ 2850-2869).

28-B. Hospital mortgage loan construction (§§ 2870-2883).

28-C. Nurse manpower center (§§ 2890-2892).

28-D. Practice of nursing home administration

- Title I. General provisions and public policy (§§ 2895--2895-a).
 - II. Licensing and registration (§§ 2896--2896-h).
 - III. Violations; penalties (§§ 2897--2897-d).
 - IV. Construction (§§ 2898--2898-a).
- 28-E. Review of criminal history information concerning prospective employees of nursing homes and home care services agencies (§§ 2899--2899-a).
- 28-F. Medical aid in dying (§§ 2899-d--2899-s).
- 29. Hospital survey, planning and review (§§ 2901-2907).
- 29-A. Access to community health care services in rural areas.
 - Title I. Rural health care access (§§ 2950-2958).
 - 1-A. Rural dentistry pilot program (§ 2958-a).
- 29-AA. Patient centered medical homes (§ 2959-a).
- 29-C. Health care agents and proxies (§§ 2980-2994).
- 29-CC. Family health care decisions act (§§ 2994-a--2994-u).
- 29-CCC. Nonhospital orders not to resuscitate (§§ 2994-aa--2994-gg).
- 29-CCCC. CARE act (caregiver advise, record and enable act) (§§ 2994-hh--2994-mm).
- 29-D. Health information and quality improvement.
 - Title I. Health information (§§ 2995--2997-f-1).
 - 1-A. Safe patient handling (§§ 2997-g--2997-l).
 - II. Quality improvement (§§ 2998--2999-a).
 - 3. Pay for performance (§§ 2999-b--2999-f).
 - 4. New York state medical indemnity fund (§§ 2999-g--2999-j).
 - 5. New York state hospital quality initiative (§ 2999-m).
- 29-E. Accountable care organizations demonstration program (§§ 2999-n--2999-r).
- 29-EE. Program of all-inclusive care for the elderly (§§ 2999-s--2999-y).
- 29-F. Improved integration of health care and financing (§§ 2999-aa--2999-bb).
- 29-G. Telehealth delivery of services (§§ 2999-cc--2999-ee).
- 29-I. Medical services for foster children (§ 2999-gg).
- 29-J. Medical respite program (§ 2999-hh).

- 29-K. Registration of temporary health care services agencies and health care technology platforms (§§ 2999-ii--2999-mm).
- 30. Emergency medical services (§§ 3000-3034).
- 30-A. Emergency medical services personnel training act of nineteen hundred eighty-six (§§ 3050-3054).
- 30-B. Emergency medical, trauma and disaster care (§§ 3060-3066).
- 30-C. Emergency medical services for children (§§ 3070-3075).
- 31. Human blood and transfusion services
 - Title I. General provisions (§ 3100).
 - II. Regulation of the business of blood donating (§§ 3120-3122).
 - III. Blood donors of the age of eighteen years or over (§§3123-3124).
- 32. Live pathogenic microorganisms or viruses (§§ 3200-3203).
- 32-A. Recombinant DNA Experiments (§§ 3220-3223).
- 33. Controlled substances
 - Title I. General provisions (§§ 3300-3309-b).
 - II. Manufacture and distribution of controlled substances (§§ 3310-3322).
 - 2-A. Opioid stewardship act (§ 3323).
 - III. Research, instructional activities, and chemical analysis relating to controlled substances (§§ 3324-3329).
 - IV. Dispensing to ultimate users (§§ 3330-3345).
 - V. Dispensing to addicts and habitual users (§§ 3350-3352).
 - V-A. Medical use of marihuana (§§ 3360--3369-e).
 - VI. Records and reports (§§ 3370-3374).
 - VII. Offenses, violations and enforcement (§§ 3380-3397).
- 33-B Regulation of cannabinoid hemp and hemp extract (§§ 3398--3398-u).
- 34. Funeral directing
 - Title I. General provisions (§§ 3400-3404).
 - II. Licensing and registration (§§ 3420-3429).
 - III. Practice of funeral directing; funeral establishments (§§ 3440-3444).

- IV. Enforcement and discipline; violations and penalties (§§ 3450-3457).
- 35. Practice of x-ray technology
 - Title I. General provisions and public policy (§§ 3500-3501).
 - II. Licensing and registration (§§ 3502-3509).
 - III. Violations; penalties (§§ 3510-3514).
 - IV. Construction (§§ 3515-3518).
- 35-A. Ultraviolet radiation devices (§§ 3550-3556).
- 36. Home Care Services (§§ 3600-3622).
- 36-A. Medical equipment service agencies (§§ 3650-3656).
- 37. Physician's assistants and specialist's assistants (§§ 3700-3703).
- 37-A. Specialist assistants (§ 3710-3711).
- 38. Veterans health manpower center (§§ 3800-3803).
- 39. New York State Center for Agricultural Medicine and Health (§§ 3900-3908).
- 40. Hospice (§§ 4000-4015).
- 41. Vital statistics
 - Title I. General provisions (§§ 4100-4104).
 - II. Registration districts: registrars, physicians, midwives and funeral directors (§§ 4120-4124).
 - III. Registration of births (§§ 4130--4138-e).
 - III-A. Filing of certificates of dissolution of marriage (§ 4139).
 - IV. Registration of deaths; burial permits (§§ 4140-4148).
 - V. Registration of fetal deaths (§§ 4160-4163).
 - V-A. Induced viable births.
 - VI. Registration of persons in institutions (§ 4165).
 - VII. Vital statistics records (§§ 4170-4179).
- 42. Cadavers
 - Title I. Disposition (§§ 4200-4203).
 - II. Autopsy and dissection (§§ 4209-4222).
- 43. Anatomical gifts (§§ 4300-4310).
- 43-A. Request for consent to an anatomical gift (§ 4351).

- 43-B. Organ procurement and donor support
 - Title 1. Organ, tissue and body parts procurement and storage (§§ 4360-4369).
 - 2. Living organ donation (§§ 4370-4372).
- 44. Health maintenance organizations (§§ 4400-4416).
- 45. Medical referral services (§§ 4500-4503).
- 45-A. Disclosure of material transactions (§§ 4550-4552).
- 46. Continuing care retirement communities (§§ 4600-4624).
- 46-A. Fee-for-service continuing care retirement communities demonstration program (§§ 4650-4676).
- 46-B. Assisted living.
 - Title I. Findings and definitions (§§ 4650*-4651*).
 - II. Assisted living (§§ 4652*-4653*).
 - III. Enhanced assisted living certificate (§§ 4654*-4655*).
 - IV. General requirements (§§ 4656*-4663*).
- 47. Shared health facilities (§§ 4700-4718).
- 48. Toxic substances (§§ 4800-4808).
- 49. Utilization review.
 - Title I. Certification of agents and utilization review process (§§ 4900-4908).
 - II. Right to external appeal (§§ 4910-4917).
- 49-A. Medical debt reporting (§§ 4925-4927).
- 50. Separability clause; saving clause; construction; laws repealed; time of taking effect (§§ 5000-5003).

ARTICLE I

SHORT TITLE AND DEFINITIONS: GENERAL PROVISIONS

- Title I. Short title and definitions (§§ 1-2).
- II. General provisions (§§ 10-24).
- III. Office of the Medicaid inspector general (§§ 30-36).

TITLE I

SHORT TITLE AND DEFINITIONS

- Section 1. Short title.

2. Definitions.

§ 1. Short title. This chapter shall be known as the "Public Health Law."

§ 2. Definitions. 1. Whenever used in this chapter, unless otherwise expressly stated or unless the context or subject matter requires a different meaning, the following terms shall have the respective meanings hereinafter set forth or indicated:

(a) Department. The term "department" means department of health of the state of New York.

(b) Commissioner. The term "commissioner" means commissioner of health of the state of New York.

(c) Health district. The term "health district" means a county health district, part-county health district, city, town, village or consolidated health district having a separate board of health.

(d) County health district. The term "county health district" means a health district comprising the entire county heretofore or hereafter established.

(e) Part-county health district. The term "part-county health district" means all that part of a county outside of a city or cities having a population of fifty thousand or more heretofore or hereafter established as a health district.

(f) County department of health. The term "county department of health" means that division of the county government having jurisdiction over the public health of a county or part-county health district.

(g) County health commissioner. The term "county health commissioner" means the executive officer of a county department of health.

(h) Local board of health. The term "local board of health" means the board of health of a county, part-county, city, village, town or consolidated health district.

(i) Municipality. The term "municipality" means a city, village, town or consolidated health district.

(j) Local health officer. The term "local health officer" means the health officer of a county, part-county, city, village, town or a

consolidated health district.

(k) Sanitary code. The term "sanitary code" means sanitary code of the state of New York.

(l) Communicable disease. The term "communicable disease" means infectious, contagious or communicable disease.

(m) State institution in the department. The term "state institution in the department" means any state hospital or institution subject to the jurisdiction, supervision and control of the state department of health, and such other state hospitals and institutions as may hereafter be made subject to the jurisdiction, supervision and control of the state department of health.

(n) Sexually transmissible disease. The term "sexually transmissible disease" shall mean a disease that appears on the list of diseases promulgated by the commissioner pursuant to section twenty-three hundred eleven of this chapter.

2. Whenever the term "state board of health" occurs or any reference is made thereto, in any law, it shall be deemed to mean or refer to the department as described in this article.

3. Whenever the term "public health council" or "state hospital review and planning council" occurs, or any reference is made thereto, in any law, it shall be deemed to mean or refer to the public health and health planning council as described in article two of this chapter.

TITLE II

GENERAL PROVISIONS

Section 10. Legal presumptions; evidence.

11. Rules and regulations of the department; evidence.

12. Violations of health laws or regulations; penalties and injunctions.

12-a. Formal hearings; notice and procedure.

12-b. Wilful violation of health laws.

12-c. Obstructing health officer in performance of his duty.

12-d. Filing of certain information by medical facilities.

13. Enforcement: against officers.

14. Actions against persons rendering professional services at the request of the department; defense and indemnification.
15. Examination and inspection of public works.
16. Summary action.
17. Release of medical records.
18. Access to patient information.
- 18*2. Registration and notification of boards of directors or trustees of certain voluntary, not-for-profit facilities or corporations.
- 18-a. Disclosure of information.
- 18-b. Procedures in the course of education or training; consent.
- 18-c. Separate patient consent for treatment and payment for health care services.
19. Reasonable charges for medicare beneficiaries.
20. Accelerated death benefits.
22. Health-related legal services program.
23. Claim forms.
24. Disclosure.

§ 10. Legal presumptions; evidence. 1. The actions, proceedings, authority, and orders of the department in enforcing the provisions of the public health law and the sanitary code applying them to specific cases shall at all times be regarded as in their nature judicial, and shall be treated as prima facie just and legal.

2. The written reports of state and local health officers, inspectors, investigators, nurses and other representatives of state and local health officers on questions of fact pertaining to, concerning or arising under and in connection with complaints, alleged violations, investigations, proceedings, actions, authority and orders, related to the enforcement of this chapter, the sanitary code or any local health regulation shall be presumptive evidence of the facts so stated therein, and shall be received as such in all courts and places. The persons making such reports shall be exempt from personal liability for the

statements therein made, if they have acted in good faith.

§ 11. Rules and regulations of the department; evidence. 1. The rules and regulations of the department promulgated pursuant to the provisions of this chapter may be read in evidence from the official compilation of codes, rules and regulations of the state of New York, or supplement thereto. To entitle any copy of the said rules and regulations, other than those in the official compilation or supplement thereto, to be read in evidence there shall be contained in the same book or pamphlet a printed certificate of the secretary of state that such copy is a correct transcript of the text of the said rules and regulations as published in the official compilation or supplement thereto. For such a certificate the secretary of state shall collect such a fee as he shall deem just and reasonable.

2. All regulations of the department on file in the department and in the office of the secretary of state on the date when this chapter takes effect shall continue to be binding and in force except as may be inconsistent with this chapter and as amended or repealed from time to time.

§ 12. Violations of health laws or regulations; penalties and injunctions. * 1. (a) Except as provided in paragraphs (b) and (c) of this subdivision, any person who violates, disobeys or disregards any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto for which a civil penalty is not otherwise expressly prescribed by law, shall be liable to the people of the state for a civil penalty of not to exceed two thousand dollars for every such violation.

(b) The penalty provided for in paragraph (a) of this subdivision may be increased to an amount not to exceed five thousand dollars for a subsequent violation if the person committed the same violation, with respect to the same or any other person or persons, within twelve months of the initial violation for which a penalty was assessed pursuant to paragraph (a) of this subdivision and said violations were a serious

threat to the health and safety of an individual or individuals.

(c) The penalty provided for in paragraph (a) of this subdivision may be increased to an amount not to exceed ten thousand dollars if the violation directly results in serious physical harm to any patient or patients.

Effective on and after April first, two thousand eight the comptroller is hereby authorized and directed to deposit amounts collected in excess of two thousand dollars per violation to the patient safety center account to be used for purposes of the patient safety center created by title two of article twenty-nine-D of this chapter.

* NB Effective until April 1, 2029

* 1. Any person who violates, disobeys or disregards any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto for which a civil penalty is not otherwise expressly prescribed by law, shall be liable to the people of the state for a civil penalty of not to exceed two thousand dollars for every such violation.

* NB Effective April 1, 2029

2. The penalty provided for in subdivision one of this section may be recovered by an action brought by the commissioner in any court of competent jurisdiction.

3. Nothing in this section contained shall be construed to alter or repeal any existing provision of law declaring such violations or any of them to be misdemeanors or felonies or prescribing the penalty therefor.

4. Such civil penalty may be released or compromised by the commissioner before the matter has been referred to the attorney general, and where such matter has been referred to the attorney general, any such penalty may be released or compromised and any action commenced to recover the same may be settled and discontinued by the attorney general with the consent of the commissioner.

5. It shall be the duty of the attorney general upon the request of the commissioner to bring an action for an injunction against any person

who violates, disobeys or disregards any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto; provided, however, that the commissioner shall furnish the attorney general with such material, evidentiary matter or proof as may be requested by the attorney general for the prosecution of such an action.

6. It is the purpose of this section to provide additional and cumulative remedies, and nothing herein contained shall abridge or alter rights of action or remedies now or hereafter existing, nor shall any provision of this section, nor any action done by virtue of this section, be construed as estopping the state, persons or municipalities in the exercising of their respective rights to suppress nuisances or to prevent or abate pollution.

§ 12-a. Formal hearings; notice and procedure. 1. The commissioner, or any person designated by him for this purpose, may issue subpoenas and administer oaths in connection with any hearing or investigation under or pursuant to this chapter, and it shall be the duty of the commissioner and any persons designated by him for such purpose to issue subpoenas at the request of and upon behalf of the respondent.

2. The commissioner and those designated by him shall not be bound by the laws of evidence in the conduct of hearing proceedings, but the determination shall be founded upon sufficient legal evidence to sustain it.

3. Notice of hearing shall be served at least fifteen days prior to the date of the hearing, provided that, whenever because of danger to the public health it appears prejudicial to the interests of the people of the state to delay action for fifteen days, the commissioner may serve the respondent with an order requiring certain action or the cessation of certain activities immediately or within a specified period of less than fifteen days and the commissioner shall provide an opportunity to be heard within fifteen days after the date the order is served.

4. Service of notice of hearing or order shall be made by personal service or by registered or certified mail. Where service, whether by personal service or by registered or certified mail, is made upon an infant, incompetent, partnership, corporation, governmental subdivision, board or commission, it shall be made upon the person or persons designated to receive personal service by article three of the civil practice law and rules.

5. The attorney-general may prefer charges, attend hearings, present the facts, and take any and all proceedings in connection therewith.

6. At a hearing, the respondent may appear personally, shall have the right of counsel, and may cross-examine witnesses against him and produce evidence and witnesses in his behalf.

7. Following a hearing, the commissioner may make appropriate determinations and issue an order in accordance therewith.

8. The commissioner may adopt, amend and repeal administrative rules and regulations governing the procedures to be followed with respect to hearings, such rules to be consistent with the policy and purpose of this chapter and the effective and fair enforcement of its provisions.

9. The provisions of this section shall be applicable to all hearings held pursuant to this chapter, except where other provisions of this chapter applicable thereto are inconsistent therewith, in which event such other provisions shall apply.

§ 12-b. Wilful violation of health laws. 1. A person who wilfully violates or refuses or omits to comply with any lawful order or regulation prescribed by any local board of health or local health officer, is guilty of a misdemeanor; except, however, that where such order or regulation applies to a tenant with respect to his own dwelling unit or to an owner occupied one or two family dwelling, such person is guilty of an offense for the first violation punishable by a fine not to exceed fifty dollars and for a second or subsequent violation is guilty

of a misdemeanor punishable by a fine not to exceed five hundred dollars or by imprisonment not to exceed six months or by both such fine and imprisonment.

* 2. A person who wilfully violates any provision of this chapter, or any regulation lawfully made or established by any public officer or board under authority of this chapter, the punishment for violating which is not otherwise prescribed by this chapter or any other law, is punishable by imprisonment not exceeding one year, or by a fine not exceeding ten thousand dollars or by both. Effective on and after April first, two thousand eight the comptroller is hereby authorized and directed to deposit amounts collected in excess of two thousand dollars per violation to the patient safety center account to be used for purposes of the patient safety center created by title two of article twenty-nine-D of this chapter.

* NB Effective until April 1, 2029

* 2. A person who wilfully violates any provision of this chapter, or any regulation lawfully made or established by any public officer or board under authority of this chapter, the punishment for violating which is not otherwise prescribed by this chapter or any other law, is punishable by imprisonment not exceeding one year, or by a fine not exceeding two thousand dollars or by both.

* NB Effective April 1, 2029

§ 12-c. Obstructing health officer in performance of his duty. A person who wilfully opposes or obstructs a health officer or physician charged with enforcement of the health laws, in performing any legal duty, is guilty of a misdemeanor.

§ 12-d. Filing of certain information by medical facilities. 1. In the event a medical facility fails to file the required financial and statistical reports, or specific additional data related to the rate setting process, on or before the prescribed due dates, or as the same may be extended by the commissioner, the commissioner shall reduce the current rate established for payments by governmental agencies by up to two percent for a period beginning on the first day of the calendar

month following the original due date of the required reports or additional data and continuing until the last day of the calendar month in which said reports or data are filed.

2. If the financial and statistical reports required by this section are determined by the commissioner to be incomplete, inaccurate or incorrect, the medical facility will have thirty days from the date of receipt of notification to provide the corrected or additional data. Failure to file the corrected or additional data that was previously required within such thirty day period, or as the same may be extended by the commissioner, shall result in a reduction of the current rate in accordance with subdivision one of this section.

3. For purposes of this section, "specific additional data related to the rate setting process", shall mean those for use in a wage geographic differential survey, a peer grouping data survey and a medical supplies survey and a malpractice insurance survey, as well as other information intended for use in establishing rates. The commissioner shall supply each medical facility with preliminary information concerning the data that will be required prior to the start of each rate period. Failure to file such additional data within thirty days from the date of receipt of notification to supply such information, or as the same may be extended by the commissioner, shall result in a reduction of the current rate in accordance with subdivision one of this section.

4. For the purposes of this section, "medical facility" shall mean a residential health care facility, general hospital, free-standing ambulatory care facility, diagnostic and/or treatment center and clinic authorized under article twenty-eight of this chapter, and a certified home health agency and long term home health care program authorized under article thirty-six of this chapter.

§ 13. Enforcement: against officers. The performance of any duty or the doing of any act enjoined, prescribed or required by this chapter, may be enforced by a proceeding pursuant to article seventy-eight of the civil practice law and rules at the instance of the department or of a

local board of health, or of any citizen of full age resident of the municipality where the duty should be performed or the act done.

§ 14. Actions against persons rendering professional services at the request of the department; defense and indemnification. The provisions of section seventeen of the public officers law shall apply to any physician, dentist, nurse or other health care professional who: (i) is licensed to practice pursuant to article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-three, one hundred thirty-six, one hundred thirty-seven, one hundred thirty-nine, one hundred forty-three, one hundred fifty-six, one hundred fifty-seven, one hundred fifty-nine or one hundred sixty-four of the education law and who is rendering professional treatment or consultation in connection with professional treatment authorized under such license at the request of the department, or at a departmental facility, including clinical practice provided pursuant to a clinical practice plan established pursuant to subdivision fourteen of section two hundred six of this chapter, to patients receiving care or professional consultation from the department while rendering such professional treatment or consultation; (ii) is rendering consultation in connection with an audit or prepayment review of claims or treatment requests under the medical assistance program; or (iii) assists the department as consultants or expert witnesses in the investigation or prosecution of alleged violations of article twenty-eight, thirty-six, forty-four or forty-seven of this chapter or rules and regulations adopted pursuant thereto.

§ 15. Examination and inspection of public works. All persons having the control, charge or custody of any public structure, work or ground, or of any plan, description, outline, drawing or chart thereof or relating thereto, made, kept or controlled by or under any public authority, shall permit and facilitate the examination, inspection and copying thereof by the commissioner, or by any person authorized by him to make such examination or inspection of such copies.

§ 16. Summary action. Whenever the commissioner, after investigation, is of the opinion that any person is causing, engaging in or maintaining a condition or activity which in his opinion constitutes danger to the health of the people, and that it therefore appears to be prejudicial to the interests of the people to delay action for fifteen days until an opportunity for a hearing can be provided in accordance with the provisions of section twelve-a of this chapter, the commissioner shall order the person, including any state agency or political subdivision having jurisdiction, by written notice to discontinue such dangerous condition or activity or take certain action immediately or within a specified period of less than fifteen days. As promptly as possible thereafter, within not to exceed fifteen days, the commissioner shall provide the person an opportunity to be heard and to present any proof that such condition or activity does not constitute a danger to the health of the people.

§ 17. Release of medical records. Upon the written request of any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or conservator of a conservatee, an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all x-rays, medical records and test records including all laboratory tests regarding that patient to any other designated physician or hospital provided, however, that such records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant, and provided, further, that original mammograms, rather than copies thereof, shall be released and delivered. Either the physician or hospital incurring the expense of providing copies of x-rays, medical records and test records including all laboratory tests pursuant to the provisions of this section may impose a reasonable charge to be paid by the person requesting the release and deliverance of such records as reimbursement for such expenses, provided, however, that the physician or hospital may not impose a

charge for copying an original mammogram when the original has been released or delivered to any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a conservator of a conservatee and provided, further, that any charge for delivering an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A release of records under this section shall not be denied solely because of inability to pay. No charge may be imposed under this section for providing, releasing, or delivering medical records or copies of medical records where requested for the purpose of supporting an application, claim or appeal for any government benefit or program, provided that, where a provider maintains medical records in electronic form, it shall provide the copy in either electronic or paper form, as required by the government benefit or program, or at the patient's request.

For the purposes of this section the term "laboratory tests" shall include but not be limited to tests and examinations administered in clinical laboratories or blood banks as those terms are defined in section five hundred seventy-one of this chapter.

*** § 18. Access to patient information.** 1. Definitions. For the purpose of this section:

(a) "Committee" means a medical access review committee appointed pursuant to subdivision four of this section.

(b) "Health care provider" or "provider" means a "health care facility" or a "health care practitioner" as defined by this subdivision.

(c) "Health care facility" or "facility" means a hospital as defined in article twenty-eight of this chapter, a home care services agency as defined in article thirty-six of this chapter, a hospice as defined in article forty of this chapter, a health maintenance organization as defined in article forty-four of this chapter, and a shared health facility as defined in article forty-seven of this chapter.

(d) "Health care practitioner" or "practitioner" means a person

licensed under article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four, one hundred fifty-six or one hundred fifty-nine of the education law or a person certified under section twenty-five hundred sixty of this chapter.

(e) "Patient information" or "information" means any information concerning or relating to the examination, health assessment including, but not limited to, a health assessment for insurance and employment purposes or treatment of an identifiable subject maintained or possessed by a health care facility or health care practitioner who has provided or is providing services for assessment of a health condition including, but not limited to, a health assessment for insurance and employment purposes or has treated or is treating such subject, except (i) information and clinical records subject to the provisions of section 23.05 or 33.13 of the mental hygiene law, (ii) personal notes and observations of a health care practitioner, provided that such personal notes and observations are maintained by the practitioner and not disclosed by the practitioner to any other person after January first, nineteen hundred eighty-seven, (iii) information maintained by a practitioner, concerning or relating to the prior examination or treatment of a subject received from another practitioner, provided however, that such information may be requested by the subject directly from such other practitioner in accordance with the provisions of this section, and (iv) data disclosed to a practitioner in confidence by other persons on the basis of an express condition that such data would never be disclosed to the subject or other persons, provided that such data has never been disclosed to any other person. If at any time such personal notes and observations or such data is disclosed, it shall be considered patient information for purposes of this section. For purposes of this subdivision, "disclosure to any other person" shall not include disclosures made to practitioners as part of a consultation or referral during the treatment of the subject, to persons reviewing information or records in the ordinary course of ensuring that a provider is in compliance with applicable quality of care, licensure or accreditation standards, to an employee or official of a federal, state

or local agency for the sole purpose of conducting an audit in the course of his or her official duties, to the statewide planning and research cooperative system, to other persons pursuant to a court order, to governmental agencies, insurance companies licensed pursuant to the insurance law and other third parties requiring information necessary for payments to be made to or on behalf of patients, to qualified researchers, to the state board for professional medical conduct when such board requests such information in the exercise of its statutory function, to an insurance carrier insuring, or an attorney consulted by, a health care provider, or to a health maintenance organization certified pursuant to article forty-four of this chapter or licensed pursuant to the insurance law, or to the committee or a court pursuant to the provisions of this section.

For purposes of this subdivision treatment of a subject shall not include diagnostic services, except mammography, performed by a practitioner at the request of another health care practitioner provided, however, that such information, and mammograms, may be requested by the subject directly from the practitioner at whose request such diagnostic services were performed, in accordance with the provisions of this section.

(f) "Personal notes and observations" means a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders, provided such data is maintained by a practitioner.

(g) "Qualified person" means any properly identified subject; or a guardian appointed under article eighty-one of the mental hygiene law; or a parent of an infant; or a guardian of an infant appointed under article seventeen of the surrogate's court procedure act or other legally appointed guardian of an infant who may be entitled to request access to a clinical record under paragraph (c) of subdivision two of this section; or a distributee of any deceased subject for whom no personal representative, as defined in the estates, powers and trusts law, has been appointed; or an attorney representing a qualified person or the subject's estate who holds a power of attorney from the qualified person or the subject's estate explicitly authorizing the holder to execute a written request for patient information under this section. A qualified person shall be deemed a "personal representative of the

individual" for purposes of the federal health insurance portability and accountability act of 1996 and its implementing regulations.

(h) "Subject" means an individual concerning whom patient information is maintained or possessed by a health care provider.

(i) "Treating practitioner" means the health care practitioner who has primary responsibility for the care of the subject within the health care facility or if such practitioner is unavailable, a practitioner designated by such facility.

(j) "Cease to do business in this state" shall mean any case where a health care provider who has engaged in an on-going practice or business within this state as a health care provider, ceases to engage in such business, provided however, that this term shall not include a health care practitioner whose practice is merged, consolidated, combined, or acquired by another health care provider and he or she continues to provide services including medical care, diagnosis or treatment to patients as an employee, contractor, or owner of the merged, consolidated, combined, or acquired health care provider.

2. Access by qualified persons. (a) Subject to the provisions of subdivision three of this section, upon the written request of any subject, a health care provider shall provide an opportunity, within ten days, for such subject to inspect any patient information concerning or relating to the examination or treatment of such subject in the possession of such health care provider.

(b) Subject to the provisions of subdivision three of this section, upon the written request of the committee for an incompetent appointed pursuant to article seventy-eight of the mental hygiene law, a health care provider shall provide an opportunity, within ten days, for the inspection by such committee of any patient information concerning the incompetent subject in the possession of such health care provider.

(c) Subject to the provisions of subdivision three of this section and except as otherwise provided by law, upon the written request of a parent or guardian of an infant appointed pursuant to article seventeen of the surrogate's court procedure act, or any other legally appointed guardian, a health care provider shall provide an opportunity, within ten days, for such parent or guardian to inspect any patient information maintained or possessed by such provider concerning care and treatment

of the infant for which the consent of such parent or guardian was obtained or where care was provided without consent in an emergency which was the result of accidental injury or the unexpected onset of serious illness; provided, however, that such parent or guardian shall not be entitled to inspect or make copies of any patient information concerning the care and treatment of an infant where the health care provider determines that access to the information requested by such parent or guardian would have a detrimental effect on the provider's professional relationship with the infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents or guardian.

(d) Subject to the provisions of subdivision three of this section, upon the written request of any qualified person, a health care provider shall furnish to such person, within a reasonable time, a copy of any patient information requested, and original mammograms requested, which the person is authorized to inspect pursuant to this subdivision. A qualified person may request a physical copy of any patient information requested pursuant to this section.

(e) The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider, provided, however, that a provider may not impose a charge for copying an original mammogram when the original has been furnished to any qualified person and provided, further, that any charge for furnishing an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A qualified person shall not be denied access to patient information solely because of inability to pay. No charge may be imposed under this section for providing, releasing, or delivering patient information or copies of patient information where requested for the purpose of supporting an application, claim or appeal for any government benefit or program, provided that, where a provider maintains patient information in electronic form, it shall provide the copy in either electronic or paper form, as required by the government benefit or program, or at the patient's request.

(f) A provider may place reasonable limitations on the time, place, and frequency of any inspections of patient information.

(g) In the event that a practitioner does not have space available to permit the inspection of patient information, the practitioner may, in the alternative, furnish a qualified person a copy of such information within ten days.

(h) A provider may request the opportunity to review the patient information with the qualified person requesting such information, but such review shall not be a prerequisite for furnishing the information.

(i) A provider may make available for inspection either the original or a copy of patient information.

3. Limitations on access. (a) Upon receipt of a written request by a qualified person to inspect or copy patient information, a practitioner may review the information requested. Unless the practitioner determines pursuant to paragraph (d) of this subdivision that (i) the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right to access to the information, or (ii) the material requested is personal notes and observations, or the information requested would have a detrimental effect as defined in subdivision two of this section, review of such patient information shall be permitted or copies provided.

(b) Upon receipt of a written request by a qualified person to inspect patient information maintained by a facility, the facility shall inform the treating practitioner of the request. The treating practitioner may review the information requested. Unless the treating practitioner determines, pursuant to paragraph (d) of this subdivision that the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information or would have a detrimental effect as defined in subdivision two of this section, review of such patient information shall be permitted or copies provided.

(c) A subject over the age of twelve years may be notified of any request by a qualified person to review his/her patient information, and, if the subject objects to disclosure, the provider may deny the request. In the case of a facility, the treating practitioner shall be consulted.

(d) The provider may deny access to all or a part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the provider determines that (i) the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information, or would have a detrimental effect as defined in subdivision two of this section, or (ii) the material requested is personal notes and observations. In conducting such review, the provider may consider, among other things, the following factors: (i) the need for, and the fact of, continuing care and treatment; (ii) the extent to which the knowledge of the information may be harmful to the health or safety of the subject or others; (iii) the extent to which the information contains sensitive material disclosed in confidence to the practitioner or treating practitioner by family members, friends and other persons; (iv) the extent to which the information contains sensitive materials disclosed to the practitioner or the treating practitioner by the subject which would be injurious to the subject's relationships with other persons, except when the subject is requesting information concerning himself or herself; and (v) in the case of a minor making a request for access pursuant to subdivision two of this section, the age of the subject.

(e) In the event of a denial of access, the qualified person shall be informed by the provider of such denial, and whether the denial is based on the reasonable expectation that release of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which outweighs the qualified person's right of access to the information or on the reasonable expectation that release of the information would have a detrimental effect as defined in subdivision two of this section, or on the basis that the materials sought to be reviewed constitute personal notes and observations, and of the qualified person's right to obtain, without cost, a review of the denial by the appropriate medical record access review committee. If the qualified person requests such review, the provider shall, within ten days of receipt of such request, transmit the information including personal notes and observations as defined herein, to the chairman of the appropriate committee with a statement setting forth the specific

reasons for which access was denied. After an in camera review of the materials provided and after providing all parties a reasonable opportunity to be heard, the committee shall promptly make a written determination whether the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which outweighs the qualified person's right of access to the information pursuant to paragraph (d) of this subdivision or whether the requested review would have a detrimental effect as defined in subdivision two of this section, or whether all or part of the materials sought to be reviewed constitute personal notes and observations, and shall accordingly determine whether access to all or part of such materials shall be granted. In the event that the committee determines that the request for access shall be granted in whole or in part, the committee shall notify all parties and the provider shall grant access pursuant to such determination.

(f) In the event that access is denied in whole or in part because the requested review of information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information, or would have a detrimental effect as defined in subdivision two of this section, the committee shall notify the qualified person of his or her right to seek judicial review of the provider's determination pursuant to this section: provided however, that a determination by the committee as to whether materials sought to be reviewed constitute personal notes and observations shall not be the subject of judicial review. Within thirty days of receiving notification of such decision, the qualified person may commence, upon notice, a special proceeding in supreme court for a judgment requiring the provider to make available the information for inspection or copying. The court upon such application and after an in camera review of the materials provided including the determination and record of the committee, and after providing all parties an opportunity to be heard, shall determine whether there exists a reasonable basis for the denial of access. The relief available pursuant to this section shall be limited to a judgement requiring the provider to make available to the qualified person the requested information for inspection or copying.

(g) Where the written request for patient information under this

section is signed by a distributee of a deceased subject for whom a personal representative has not been appointed, or from the holder of a power of attorney from such a distributee, a copy of a certified copy of the certificate of death of the subject shall be attached to the written request.

(h) Where the written request for patient information under this section is signed by the holder of a power of attorney, a copy of the power of attorney shall be attached to the written request. A written request under this subdivision shall be subject to the duration and terms of the power of attorney.

(i) The release of patient information shall be subject to: (i) article twenty-seven-F of this chapter in the case of confidential HIV-related information; (ii) section seventeen of this article and sections twenty-three hundred one, twenty-three hundred six and twenty-three hundred eight of this chapter in the case of termination of a pregnancy and treatment for a sexually transmitted disease; (iii) article thirty-three of the mental hygiene law; and (iv) any other provisions of law creating special requirements relating to the release of patient information, including the federal health insurance portability and accountability act of 1996 and its implementing regulations.

4. Medical record access review committees. The commissioner shall designate medical record access review committees to hear appeals of the denial of access to patient information as provided in paragraph (e) of subdivision three of this section. The commissioner shall promulgate rules and regulations necessary to effectuate the provisions of this subdivision.

5. Annual report. The commissioner shall submit an annual report on or before December thirty-first to the governor and the legislature. Such report shall include, but not be limited to, the number of requests for committee review of providers' denial of access and the committees' determinations thereon.

6. Disclosure to third persons. Whenever a health care provider, as otherwise authorized by law, discloses patient information to a person

or entity other than the subject of such information or to other qualified persons, either a copy of the subject's written authorization shall be added to the patient information or the name and address of such third party and a notation of the purpose for the disclosure shall be indicated in the file or record of such subject's patient information maintained by the provider provided, however, that for disclosures made to government agencies making payments on behalf of patients or to insurance companies licensed pursuant to the insurance law such a notation shall only be entered at the time the disclosure is first made. This subdivision shall not apply to disclosure to practitioners or other personnel employed by or under contract with the facility, or to government agencies for purposes of facility inspections or professional conduct investigations. Any disclosure made pursuant to this section shall be limited to that information necessary in light of the reason for disclosure. Information so disclosed should be kept confidential by the party receiving such information and the limitations on such disclosure in this section shall apply to such party.

7. Applicability of federal law. Whenever federal law or applicable federal regulations affecting the release of patient information are a condition for the receipt of federal aid, and are inconsistent with the provisions of this section, the provisions of federal law or federal regulations shall be controlling.

8. Challenges to accuracy. A qualified person may challenge the accuracy of information maintained in the patient information and may require that a brief written statement prepared by him or her concerning the challenged information be inserted into the patient information. This statement shall become a permanent part of the patient information and shall be released whenever the information at issue is released. This subdivision shall apply only to factual statements and shall not include a provider's observations, inferences or conclusions.

A facility may place reasonable restrictions on the time and frequency of any challenges to accuracy.

9. Waivers void. Any agreement by an individual to waive any right to

inspect, copy or seek correction of patient information as provided for in this section shall be deemed to be void as against public policy and wholly unenforceable.

10. Nothing contained in this section shall restrict, expand or in any way limit the disclosure of any information pursuant to articles twenty-three, thirty-one and forty-five of the civil practice law and rules or section six hundred seventy-seven of the county law.

11. No proceeding shall be brought or penalty assessed, except as provided for in this section, against a health care provider, who in good faith, denies access to patient information.

12. Immunity from liability. No health care provider shall be subjected to civil liability arising solely from granting or providing access to any patient information in accordance with this section.

13. (a) A health care provider which has in its possession patient information and/or patient medical records and which has determined to permanently cease to do business or practice in this state shall, at least thirty days prior to such action, make a good faith effort to notify each of the health care provider's current patients that the office will be closing and to inform each such patient of his or her right to request that his or her patient information and/or patient medical records be sent to a health care provider, health care facility or health care practitioner of the patient's choosing or, alternatively, that such information and records be returned to the patient.

(b) The provisions of this subdivision shall not affect any rights afforded pursuant to section seventeen of this title.

(c) Nothing in this subdivision shall affect the period of time that a health care provider is lawfully required to retain a patient's medical information and medical records.

(d) The provisions of this subdivision shall only apply with respect to a patient whose chart includes written permission to receive the notification described in paragraph (a) of this subdivision.

* NB There are 2 § 18's

*** § 18. Registration and notification of boards of directors or trustees of certain voluntary, not-for-profit facilities or corporations.** 1. Notwithstanding any other law, rule or regulation, the executive director, chairperson or president of a voluntary, not-for-profit corporation or facility which is subject to the jurisdiction of the department shall furnish annually to the commissioner a list of the names and addresses of the current members of the board of directors or trustees of such facility or corporation. Failure to furnish such annual list shall remove such facility from consideration for recertification.

2. In the event that such facility or corporation is found to be in violation of the provisions of this chapter or of rules and regulations promulgated pursuant to this chapter which could result in the revocation, cancellation, limitation or suspension of the operating certificate of such facility and if notice of such violation is provided to the facility pursuant to such regulations, a copy of such notice shall be provided to each of the current members of the board of directors or trustees of such facility or corporation by the commissioner.

3. The commissioner is authorized to promulgate such rules and regulations as are necessary to implement the provisions of this section.

* NB There are 2 § 18's

§ 18-a. Disclosure of information. 1. Each health care professional licensed, registered or certified pursuant to title eight of the education law shall, upon request, provide to his or her patient or prospective patient the following:

(a) information related to the health care professional's educational background, experience, training, specialty, and board certification, if applicable;

(b) affiliation with any health care facility licensed pursuant to article twenty-eight, thirty-six or forty-four of this chapter, and any

facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law;

(c) information regarding the health care professional's participation in continuing education programs and compliance with any licensure, certification or registration requirements, if applicable; and

(d) information regarding the health care professional's participation in clinical performance reviews conducted by the department where applicable and where available.

2. Nothing contained herein shall require written disclosure of the information described in subdivision one by the health care professional to the patient.

§ 18-b. Procedures in the course of education or training; consent. In the case of any health care procedure or examination, the fact that it is performed in the course of education or training shall not diminish the requirement for informed consent for the procedure or examination.

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

§ 19. Reasonable charges for medicare beneficiaries. 1. No physician licensed under article one hundred thirty-one of the education law shall charge from a beneficiary of health insurance under title XVIII of the

federal social security act (medicare) any amount in excess of the following limitations:

(a) Effective January first, nineteen hundred ninety-one, a physician's charge shall not exceed one hundred fifteen percent of the reasonable charge for that service as determined by the United States secretary for health and human services.

(b) Beginning January first, nineteen hundred ninety-three, a physician's charge shall not exceed one hundred ten percent of the reasonable charge for that service as determined by the United States secretary for health and human services, provided however, that if the statewide percentage of medicare part B claims billed at or below the reasonable charge as determined by the United States secretary for health and human services for federal fiscal year nineteen hundred eighty-nine fails to increase by five percentage points for federal fiscal year nineteen hundred ninety-two, such physician's charge shall, thereafter, not exceed one hundred five percent of the reasonable charge as determined by the United States secretary for health and human services. If, in any subsequent federal fiscal year, such statewide percentage of medicare part B claims billed at or below such reasonable charge fails to maintain such five percentage point increase, physician's charge shall thereafter not exceed one hundred five percent of the reasonable charge as determined by the United States secretary for health and human services.

2. The charge limitation set forth in subdivision one of this section shall not apply if the service which such beneficiary is to be billed is either an office or home visit as set forth in procedure codes 90000 through 90170 in the Physician Current Procedural Terminology 4th Edition 1989.

3. The state office for the aging shall, through agreement with carriers and/or intermediaries contracted with by the federal government in this state pursuant to title XVIII of the federal social security act (medicare), obtain the percentages of physician's bills submitted at or below the reasonable charge as established by the United States secretary for health and human services, and shall issue a report by December first, nineteen hundred ninety-two and every December first,

thereafter, stating whether the percentage of bills submitted at or below such reasonable charge for federal fiscal year nineteen hundred ninety-two increased by five percentage points over the statewide percentage of bills submitted at or below such reasonable charge for federal fiscal year nineteen hundred eighty-nine and whether such percentage has been maintained for each successive federal fiscal year after nineteen hundred ninety-two.

4. Notwithstanding any inconsistent provision of this chapter, a physician who is determined, after opportunity for a hearing, to have violated the provisions of this section shall be subject for the first violation to a fine of not more than one thousand dollars nor less than the greater of three times the amount collected, or, if not collected, three times the amount charged, in excess of the limitations set forth in subdivision one of this section, and, for each additional violation committed within five years of the date of an immediately preceding violation of this section, to a fine of not more than five thousand dollars nor less than the greater of one thousand dollars or three times the amount collected, or, if not collected, three times the amount charged, in excess of the limitations set forth in subdivision one of this section; provided, however, that in no event shall the fine for an individual violation of this section be greater than five thousand dollars. In addition, where the provisions of this section have been violated, the physician shall refund to the beneficiary the amount collected in excess of the limitations set forth in subdivision one of this section.

§ 20. Accelerated death benefits. 1. For purposes of this section, "health care facility" means a hospital and residential health care facility as defined in article twenty-eight of this chapter, a home care services agency as defined in article thirty-six of this chapter, a hospice as defined in article forty of this chapter, and a continuing care retirement community as defined in article forty-six of this chapter.

2. No health care facility or practitioner shall coerce or require or

attempt to coerce or require any person to accelerate payment of part or all of the death benefit or special surrender value under a life insurance policy, as authorized by paragraph one of subsection (a) of section one thousand one hundred thirteen of the insurance law, or to enter into a viatical settlement pursuant to the provisions of article seventy-eight of the insurance law, as a condition of admission, providing or continuing care.

§ 22. Health-related legal services program. 1. As used in this section, "health-related legal services program" means a program that is a collaboration between health care service providers and legal services programs to provide on site legal services without charge to assist, on a voluntary basis, income eligible patients and their families to resolve legal matters or needs that have an impact on patient health or are created or aggravated by a patient's health. For the purpose of this section, legal matters may include, but shall not be limited to:

- (a) housing, including utilities;
- (b) public or private health insurance coverage;
- (c) employment and eligibility for employment benefits;
- (d) government benefits;
- (e) immigration;
- (f) family law, including, but not limited to, domestic violence, guardianship, custody, and child support;
- (g) advance planning, including, but not limited to, wills, health care proxies, powers of attorney and permanency planning;
- (h) special education; and
- (i) debtor and creditor issues.

2. The department may designate health-related legal services programs that comply with standards and guidelines established for such programs. The department shall work with legal services organizations, community health advocacy organizations, hospitals, diagnostic and treatment centers and other primary and specialty health care providers, to establish standards and guidelines for health-related legal services programs that are designated under this section.

3. A health-related legal services program designated under this section shall be a not-for-profit entity operated by or affiliated with one or more legal services organizations, law schools, social services organizations, or health care providers, and it shall comply with the standards, guidelines and regulations under this section, and have demonstrated ability and experience to provide high quality health-related legal services meeting the needs of the population to be served.

§ 23. Claim forms. A non-participating physician shall include a claim form for a third-party payor with a patient bill for health care services, other than a bill for the patient's co-payment, coinsurance or deductible.

§ 24. Disclosure. 1. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center defined under 42 U.S.C. § 254b on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, shall disclose to patients or prospective patients in writing or through an internet website the health care plans in which the health care professional, group practice, diagnostic and treatment center or health center, is a participating provider and the hospitals with which the health care professional is affiliated prior to the provision of non-emergency services and verbally at the time an appointment is scheduled.

2. If a health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center defined under 42 U.S.C. § 254b on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, does not participate in the network of a patient's or prospective patient's health care plan, the health care professional, group practice, diagnostic and treatment center or health center, shall: (a) prior to the provision of non-emergency services, inform a patient or prospective patient that the amount or estimated

amount the health care professional will bill the patient for health care services is available upon request; and (b) upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, a schedule of fees provided under 42 U.S.C. § 254b(k)(3)(G)(i), that the health care professional, group practice, diagnostic and treatment center or health center, will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided.

3. A health care professional who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

4. A health care professional who is a physician shall, for a patient's scheduled hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency services are scheduled; and information as to how to determine the healthcare plans in which the physician participates.

5. A hospital shall establish, update and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the federal social security act.

6. A hospital shall post on the hospital's website: (a) the health

care plans in which the hospital is a participating provider; (b) a statement that (i) physician services provided in the hospital are not included in the hospital's charges; (ii) physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital, and; (iii) the prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates; (c) as applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions how to contact these groups to determine the health care plan participation of the physicians in these groups; and (d) as applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate.

7. In registration or admission materials provided in advance of non-emergency hospital services, a hospital shall: (a) advise the patient or prospective patient to check with the physician arranging the hospital services to determine: (i) the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician; and (ii) whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology and/or radiology are reasonably anticipated to be provided to the patient; and (b) provide patients or prospective patients with information as to how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services including anesthesiology, radiology and/or pathology.

8. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center defined under 42 U.S.C. § 254b on behalf of health care professionals rendering services at the group practice, diagnostic and treatment

center or health center, and a hospital shall make publicly available, and if applicable, post on their public websites, and provide to individuals who are enrollees of health care plans, a one-page written notice, in clear and understandable language, containing information on the requirements and prohibitions under 42 U.S.C. §§ 300gg-131 and 300gg-132 and article six of the financial services law relating to prohibitions on balance billing for emergency services and surprise bills, and information on contacting appropriate state and federal agencies if an individual believes a health care provider has violated any requirement described in 42 U.S.C. §§ 300gg-131 and 300gg-132 or article six of the financial services law.

9. For purposes of this section:

(a) "Health care plan" means a health insurer including an insurer licensed to write accident and health insurance subject to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of this chapter; a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law or a self-funded employee welfare benefit plan.

(b) "Health care professional" means an appropriately licensed, registered or certified health care professional pursuant to title eight of the education law.

(c) "Hospital" means a general hospital as defined in subdivision ten of section two thousand eight hundred one of this chapter.

TITLE III

OFFICE OF THE MEDICAID INSPECTOR GENERAL

Section 30. Legislative intent.

30-a. Definitions.

31. Establishment of the office of Medicaid inspector general.

32. Functions, duties and responsibilities.

33. Cooperation of agency officials and employees.

34. Transfer of employees.

35. Reports required of the inspector.
36. Disclosure of information.

§ 30. Legislative intent. This title establishes an independent office of Medicaid inspector general within the department to consolidate staff and other Medicaid fraud detection, prevention and recovery functions from the relevant governmental entities into a single office, and grants such office new powers and responsibilities. As such, this title is intended to create a more efficient and accountable structure, dramatically reorganize and streamline the state's process of detecting and combating Medicaid fraud and abuse and maximize the recoupment of improper Medicaid payments.

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

1. "Inspector" means the Medicaid inspector general created by this title.
2. "Investigation" means investigations of fraud, abuse, or illegal acts perpetrated within the medical assistance program, by providers or recipients of medical assistance care, services and supplies.
3. "Office" means the office of the Medicaid inspector general created by this title.

§ 31. Establishment of the office of Medicaid inspector general. 1. There is hereby created within the department the office of Medicaid inspector general. Pursuant to section three hundred sixty-three-a of the social services law, the department is the single state agency for the administration of the medical assistance program in New York state, provided that the office shall undertake and be responsible for the department's duties as the single state agency with respect to: (a) prevention, detection and investigation of fraud and abuse within the

medical assistance program; (b) referral of appropriate cases for criminal prosecution; and (c) recovery of improperly expended medical assistance funds. Such responsibility shall include, but not be limited to, medical assistance program audit functions, pursuant to sections three hundred sixty-four and three hundred sixty-eight-c of the social services law, and the function of medical assistance program fraud and abuse prevention, pursuant to sections one hundred forty-five-a and one hundred forty-five-b of the social services law (transferred to the New York state department of health from the former department of social services pursuant to subdivision (e) of section one hundred twenty-two of part B of chapter four hundred thirty-six of the laws of nineteen hundred ninety-seven).

2. The head of the office shall be the Medicaid inspector general who shall be appointed by the governor by and with the advice and consent of the senate. The inspector shall serve at the pleasure of the governor. The inspector shall report directly to the governor. The person appointed as inspector shall, upon his or her appointment, have not less than ten years professional experience in one or more of the following areas of expertise: law, provided the experience involves prosecution or some consideration of fraud; fraud investigation; and auditing. The inspector may possess comparable alternate experience in the area of health care or the area of senior management, in either the public or private setting, provided that such experience involves some consideration of fraud.

3. The inspector shall be compensated within the limits of funds available therefor, provided, however, such salary shall be no less than the salaries of certain state officers holding the positions indicated in paragraph (a) of subdivision one of section one hundred sixty-nine of the executive law.

§ 32. Functions, duties and responsibilities. The inspector shall have the following functions, duties and responsibilities:

1. to appoint such deputies, directors, assistants and other officers

and employees as may be needed for the performance of his or her duties and may prescribe their duties and fix their compensation within the amounts appropriated therefor;

2. to conduct and supervise activities to prevent, detect and investigate medical assistance program fraud and abuse amongst the following: the department; the offices of mental health, alcoholism and substance abuse services, temporary disability assistance, and children and family services and the office for people with developmental disabilities;

3. to coordinate, to the greatest extent possible, activities to prevent, detect and investigate medical assistance program fraud and abuse amongst the following: the department; the offices of mental health, alcoholism and substance abuse services, temporary disability assistance, and children and family services and the office for people with developmental disabilities; the commission on quality of care and advocacy for persons with disabilities; the department of education; the fiscal agent employed to operate the medical assistance information and payment system; local governments and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; the welfare inspector general, federal prosecutors, district attorneys within the state, the special investigative unit maintained by each health insurer operating within the state, and the state comptroller;

4. to solicit, receive and investigate complaints related to fraud and abuse within the medical assistance program;

5. to keep the governor, attorney general, state comptroller, temporary president and minority leader of the senate, the speaker and the minority leader of the assembly, and the heads of agencies with responsibility for the administration of the medical assistance program apprised of efforts to prevent, detect, investigate, and prosecute fraud and abuse within the medical assistance program, and to provide a quarterly briefing to the legislature on activities of the office;

6. to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program, including but not limited to: (a) referral of information and evidence to regulatory agencies and licensure boards; (b) withholding payment of medical assistance funds in accordance with state and federal laws and regulations; (c) imposition of administrative sanctions and penalties in accordance with state and federal laws and regulations; (d) exclusion of providers, vendors and contractors from participation in the program; (e) initiating and maintaining actions for civil recovery and, where authorized by law, seizure of property or other assets connected with improper payments; and entering into civil settlements; and (f) recovery of improperly expended medical assistance program funds from those who engage in fraud or abuse, or illegal or improper acts perpetrated within the medical assistance program. In the pursuit of such civil and administrative enforcement actions under this subdivision, the inspector shall consider the quality and availability of medical care and services and the best interest of both the medical assistance program and recipients;

6-a. to post on the department's internet website, within reasonably prompt fashion, all final administrative determinations issued by administrative law judges in connection with any actions taken by the office pursuant to this title;

7. to make information and evidence relating to suspected criminal acts which he or she may obtain in carrying out his or her duties available to appropriate law enforcement officials and to consult with the deputy attorney general for Medicaid fraud control, the welfare inspector general, and other state and federal law enforcement officials for coordination of criminal investigations and prosecutions.

The inspector shall refer suspected fraud or criminality to the deputy attorney general for Medicaid fraud control and make any other referrals to such deputy attorney general as required or contemplated by federal law. At any time after such referral, with ten days written notice to the deputy attorney general for Medicaid fraud control or such shorter

time as such deputy attorney general consents to, the inspector may additionally provide relevant information about suspected fraud or criminality to any other federal or state law enforcement agency that the inspector deems appropriate under the circumstances;

8. to subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony;

9. to require and compel the production of such books, papers, records and documents as he or she may deem to be relevant or material to an investigation, examination or review undertaken pursuant to this section;

10. to examine and copy or remove documents or records of any kind related to the medical assistance program or necessary for the inspector to perform its duties and responsibilities that are prepared, maintained or held by or available to any state agency or local governmental entity the patients or clients of which are served by the medical assistance program, or which is otherwise responsible for the control of fraud and abuse within the medical assistance program; provided, however, that any such information be afforded confidentiality protection as provided for under state and federal law. The removal of records shall be limited to those circumstances in which a copy thereof is insufficient for an appropriate legal or investigative purpose, provided that in such instances the copying and return of such original, or copy where the original is required for an appropriate legal or investigative purpose, is expedited and such original or copy is readily accessible in accordance with the care and treatment needs of the patient,

11. to recommend and implement policies relating to the prevention and detection of fraud and abuse; provided however, that the consent of the attorney general shall be obtained prior to the implementation of any policy that shall affect the operations of the office of the attorney general;

12. to monitor the implementation of any recommendations made by the office to agencies or other entities with responsibility for

administration of the medical assistance program;

13. to prepare cases, provide testimony and support administrative hearings and other legal proceedings;

14. to review and audit contracts, cost reports, claims, bills and all other expenditures of medical assistance program funds to determine compliance with applicable federal and state laws and regulations and take such actions as are authorized by federal or state laws and regulations;

15. to work with the fiscal agent employed to operate the Medicaid management information system to optimize the system;

16. to work in a coordinated manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the medical assistance program, including the surveillance utilization review system and other automated systems pursuant to paragraph (b) of subdivision eight of section three hundred sixty-seven-b of the social services law;

17. to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program;

18. to, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action;

19. to receive and to investigate complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud and abuse in the medical assistance program;

20. to, consistent with provisions of this title, implement and amend,

as needed, rules and regulations relating to the prevention, detection, investigation and referral of fraud and abuse within the medical assistance program and the recovery of improperly expended medical assistance program funds;

21. to conduct, in the context of the investigation of fraud and abuse, on-site facility and office inspections;

22. to take appropriate actions to ensure that the medical assistance program is the payor of last resort;

23. to annually submit a budget request, for the ensuing state fiscal year, to the division of the budget, provided that the office's budget request shall not be subject to review, alteration or modification by the commissioner or any other entity or person prior to its submission to the division of the budget;

24. to meet quarterly with representatives of social services districts to discuss the status of ongoing cooperative efforts between the office of Medicaid inspector general and districts, including demonstration programs authorized pursuant to section five-a of part C of chapter fifty-eight of the laws of two thousand five, the potential for additional collaboration and/or for improved or innovative techniques to be employed, and any issues of concern to such districts with respect to the prevention and detection of fraud and abuse in the medical assistance program;

25. to request submission of social services districts annual budget and audit workplans for purposes of planning for and executing the county demonstration program and for the creation of the office's annual workplan and to include in the office's annual workplan a description of activities that will be conducted in collaboration with social services districts;

26. to develop training materials with respect to the office's audit standards and criteria for identifying fraud or waste, for use by social services districts who are engaged with the office in demonstration

programs or other collaborative efforts; and

27. to perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office in accordance with federal and state law.

§ 33. Cooperation of agency officials and employees. 1. In addition to the authority otherwise provided by this title, the inspector, in carrying out the provisions of this title, is authorized to request such information, assistance and cooperation from any federal, state or local governmental department, board, bureau, commission, or other agency or unit thereof as may be necessary for carrying out the duties and responsibilities enjoined upon the inspector by this section. State and local agencies or units thereof are hereby authorized and directed to provide to the inspector, or, at the request of the inspector, to state agencies or their contractors, such information, assistance and cooperation. Notwithstanding any other provision of law to the contrary, requests for information, assistance and cooperation may include, but not be limited to, all state and local government birth, death and vital statistics which may be contained in files, databases or registries, and for all information shall, upon request, include, where possible, making electronic copies or record exchanges available. Executive agencies shall coordinate and facilitate the transfer of appropriate functions and positions to the office as necessary and in accordance with applicable law.

2. Upon request of a local social services district or a prosecutor of competent jurisdiction, the office, department, any other state or local government entity and the Medicaid fraud control unit shall provide such information and assistance as such entity or unit shall deem necessary, appropriate and available to aid and facilitate the investigation of fraud and abuse within the medical assistance program and the recoupment of improperly expended funds.

§ 34. Transfer of employees. Upon the transfer of the medical

assistance program audit and fraud and abuse prevention functions from the department and the offices of mental health, alcoholism and substance abuse services, temporary disability assistance, and children and family services and the office for people with developmental disabilities to the office within the department pursuant to section thirty-one of this title, provision shall be made for the transfer of necessary officers and employees who are substantially engaged in the performance of the function to be transferred, and any documents and records necessary and related to the transfer of such functions. The heads of the departments or agencies from which such function is to be transferred and the inspector shall confer to determine the officers and employees who are substantially engaged in the medical assistance program audit and fraud and abuse prevention function to be transferred. In accordance with subdivision two of section seventy of the civil service law, officers and employees so transferred shall be transferred without further examination or qualification to the same or similar titles and shall remain in the same collective bargaining unit and shall retain their respective civil service classification, status and rights pursuant to their collective bargaining unit and collective bargaining agreement. Notwithstanding the office's regional operations, all office employees shall be co-located, to the greatest extent practicable. The inspector shall have sole responsibility for establishing methods of administration for the office.

§ 35. Reports required of the inspector. 1. The inspector shall, no later than October first of each year, submit to the governor, the temporary president of the senate, the speaker of the assembly, the state comptroller and the attorney general, a report summarizing the activities of the office during the preceding calendar year. Such report shall include:

(a) the number, subject and other relevant characteristics of investigations initiated, and those completed, including but not limited to outcome, region, source of complaint and whether or not such investigation was conducted jointly with the attorney general;

(b) the number, subject and other relevant characteristics of audits initiated, and those completed, including but not limited to outcome,

region, reason for audit and the total dollar value identified for recovery and the actual recovery from such audits;

(c) the number, subject and other relevant characteristics of administrative actions initiated, and those completed, including but not limited to outcome, region and type;

(d) the number, subject and other relevant characteristics of referrals for prosecution to the deputy attorney general for Medicaid fraud control and other federal or state law enforcement agencies, or for licensure action; such information shall include but not be limited to status and region;

(e) the number, subject and other relevant characteristics of civil actions initiated by the office related to improper payments, the resulting civil settlements entered and overpayments identified and the total dollar value both identified and collected;

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

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

2. Pursuant to the reporting requirements contained within subdivision one of this section, the inspector shall not disclose information that jeopardizes an ongoing investigation or proceeding, provided that the inspector shall disclose required information that does not jeopardize an ongoing investigation or proceeding and fully apprises the designated recipients of the scope and quality of the office's activities.

3. The inspector shall, on or before April first, July first, October first and January first of each year following the calendar year in which this title shall take effect, submit to the governor, temporary president of the senate and speaker of the assembly an accountability statement providing a statistical profile of the referrals made to the state Medicaid fraud control unit, audits, investigations and

recoveries.

§ 36. Disclosure of information. The inspector shall not disclose information which is prohibited from disclosure by any other provision of law.

ARTICLE 2

THE DEPARTMENT OF HEALTH

- Title
- I. Officers and employees (§§ 200--211-a).
 - II. The public health council (§§ 220-229).
 - II-A. Professional medical conduct (§§ 230--230-e).
 - II-B. New York state health services corps (§§ 231-233).
 - II-C. Charles D. Cook office of rural health (§§ 234-237).
 - II-D. Health care practitioner referrals (§§ 238--238-e).
 - II-E. HIV/HBV/HCV prevention training (§§ 239--239-b).
 - II-F. Office of minority health (§§ 240-244).
 - III. State health areas (§§ 240-243).
 - IV. Spinal cord injury research board (§§ 250-251).
 - V. Health care practitioner volunteer pilot program (§ 260).
 - V. Obesity prevention act (§§ 260-263).
 - VI. Women's Health (§§ 266-268).
 - 6. The 21st century workgroup for disease elimination and reduction (§ 266).
 - VII. NY State of Health (§§ 268--268-h).
 - 8. Hunger prevention and nutrition assistance program (§ 269).

TITLE I

OFFICERS AND EMPLOYEES

- Section
- 200. Department of health; continuation.
 - 201. Functions, powers and duties of the department.
 - 202. Divisions.
 - 203. Commissioner; qualifications.
 - 204. Commissioner; appointment; term of office.

- 205. Commissioner; compensation and expenses.
- 206. Commissioner; general powers and duties.
- 206-a. Discrimination in hospital staff appointments and privileges prohibited.
- 206-b. Special requirements with respect to Lyme disease diagnosis.
- 207. Health care and wellness education and outreach program.
- 207-a. Tick-borne diseases and blood-borne pathogen impact study.
- 208. Deputy commissioners; appointment; qualifications and duties.
- 209. Deputy commissioners; compensation.
- 210. Officers and employees; appointment.
- 211. Training.
- 211-a. Continuation of salaries of employees of the department while receiving training.

§ 200. Department of health; continuation. There shall continue to be in the state government a department of health. The head of the department shall be the commissioner of health of the state of New York.

§ 201. Functions, powers and duties of the department. 1. The department shall, as provided by law:

- (a) supervise the work and activities of the local boards of health and health officers throughout the state, unless otherwise provided by law;
- (b) supervise and control the registration of births, deaths and marriages;
- (c) supervise the reporting and control of disease;
- (d) engage in research into morbidity and mortality;
- (e) produce, standardize and distribute diagnostic, prophylactic and therapeutic products;
- (f) conduct laboratory examinations for the diagnosis and control of disease;
- (g) promote education in the prevention and control of disease;

(h) promote or provide diagnostic and therapeutic services for maternal and child health, communicable disease, medical rehabilitation, cancer and other conditions and diseases affecting public health;

(i) except as otherwise provided by law, license, supervise and regulate maternity hospitals and homes and the occupation of midwifery;

(j) license, supervise and regulate the manufacture, distribution and use of narcotics;

(k) maintain and operate such state hospitals, institutions, public health centers and clinics as shall be established in the department;

(l) supervise and regulate the sanitary aspects of water supplies and sewage disposal and control the pollution of waters of the state;

(m) supervise and regulate the sanitary aspects of camps, hotels, boarding houses, public eating and drinking establishments, swimming pools, bathing establishments and other businesses and activities affecting public health and, in relation to hotels, boarding houses and temporary residences as defined in the state sanitary code, inspect such facilities (i) where inspections do not otherwise occur under the state uniform fire prevention and building code, (ii) to respond to complaints, or (iii) when otherwise necessary;

(n) exercise control over and supervise the abatement of nuisances affecting or likely to affect public health;

(o) advise any local unit of government and the public health officials thereof within the state, in the performance of their official duties and regulate the financial assistance granted by the state in connection with all public health activities;

(p) receive and expend funds made available for public health purposes pursuant to law;

(q) license, supervise and regulate the practice of funeral directing and embalming;

(r) supervise and regulate the public health aspects of ionizing radiation and nonionizing electromagnetic radiation; and may in its discretion license activities within the state affecting or likely to affect public health and relating to radioactive materials, excluding special nuclear materials in quantities sufficient to form a critical mass and excluding the handling and disposal of radioactive wastes and the release of radioactivity to the environment regulated by the state department of environmental conservation;

(s) administer to the medical and health needs of the ambulant sick and needy Indians on the reservations;

(u) engage in research into the causes of rocky mountain spotted fever and the prevention thereof and develop programs for the control of ticks, insects and anthropods which act as vectors of disease affecting man, within funds made available for such purposes.

(v) act as the single state agency for medical assistance pursuant to section three hundred sixty-three-a of the social services law, as amended by this chapter, with responsibility to supervise the plan for medical assistance as required by title XIX of the federal Social Security act, or its successor, and to adopt regulations as may be necessary to implement this plan.

(w) make available to the council on children and families information, in a format identified by the council, regarding home visiting programs that meet the criteria as required by section four hundred twenty-nine of the social services law regardless of whether such program has a contract with or receive funding from the state. Such information shall be provided in accordance with the requirements set forth in subdivision two of section four hundred eighty-three-h of the social services law. Such information shall be made available no less than once a year.

(x) produce an annual report analyzing the costs related to the sexual assault examination direct reimbursement program as created under subdivision thirteen of section six hundred thirty-one of the executive law and provide such report to the office of victim services on or before September first of each year. Such report shall be provided to the governor, temporary president of the senate and the speaker of the assembly.

(y) To develop a form by which a coroner, coroner's physician or medical examiner, pursuant to section six hundred seventy-seven of the county law, shall report to the division of veterans' services any death which appears to be caused by suicide by a person who, to the knowledge of the coroner, coroner's physician or medical examiner, is a veteran. This form shall at a minimum: (i) ensure compliance with the strictest privacy protections and encourage data aggregation to the extent feasible; (ii) provide the address to which the form is to be mailed or submitted electronically; and (iii) include the county of residence and

the branch of service of deceased veterans during the reporting period.

2. The department shall continue to exercise all of the functions, powers and duties which have been prescribed by law and which are being exercised by it when this chapter takes effect together with such functions, powers and duties as hereafter may be conferred and imposed upon it by law.

3. All the provisions of this chapter shall apply to the department continued by this chapter and to the commissioner, the public health council and any successor council, and to the divisions, bureaus and officers in such department.

§ 202. Divisions. 1. There shall be in the department such divisions, bureaus and other units as the commissioner from time to time may determine to be necessary and the director of the budget shall approve.

2. The commissioner may, from time to time, abolish, transfer and consolidate divisions, bureaus and other units within the department not expressly established by law as he may determine necessary for the efficient operation of the department.

§ 203. Commissioner; qualifications. The commissioner shall be a physician, a graduate of an incorporated medical college, of at least ten years' experience in the actual practice of his profession, and of skill and experience in public health duties and sanitary science.

§ 204. Commissioner; appointment; term of office. 1. The commissioner shall be appointed by the governor, by and with the advice and consent of the senate and shall hold office until the end of the term of the governor by whom he was appointed and until his successor is appointed and has qualified.

2. The present commissioner shall be the head of the department and

shall hold office until the expiration of his present term and until his successor is appointed and has qualified. If, prior to the expiration of such present term, a vacancy shall occur or exist in the office of the commissioner it shall be filled by appointment by the governor, by and with the advice and consent of the senate, for a term expiring with that of the governor by whom the appointment was made.

3. During his term of office the commissioner shall not engage in any occupation which conflicts with the performance of his official duties.

§ 205. Commissioner; compensation and expenses. The commissioner shall receive an annual salary not to exceed an amount appropriated therefor by the legislature and his expenses actually and necessarily incurred in the performance of his official duties, unless otherwise provided by the legislature.

§ 206. Commissioner; general powers and duties. 1. The commissioner shall:

(a) take cognizance of the interests of health and life of the people of the state, and of all matters pertaining thereto and exercise the functions, powers and duties of the department prescribed by law;

(b) exercise general supervision over the work of all local boards of health and health officers, unless otherwise provided by law;

(c) exercise general supervision and control of the medical treatment of patients in the state institutions, public health centers and clinics in the department;

(d) investigate the causes of disease, epidemics, the sources of mortality, and the effect of localities, employments and other conditions, upon the public health;

(e) obtain, collect and preserve such information relating to marriage, birth, mortality, disease and health as may be useful in the discharge of his duties or may contribute to the promotion of health or the security of life in the state; establish rules and regulations for the determination of asymptomatic conditions including, but not limited to RH sensitivity, anemia, sickle cell anemia, cooley's anemia and

venereal disease;

(f) enforce the public health law, the sanitary code and the provisions of the medical assistance program, or its successor, pursuant to titles eleven, eleven-A and eleven-B of the social services law, as amended by this chapter;

(g) cause to be made from time to time examinations and inspections of the sanitary conditions of each state institution and transmit copies of the reports and recommendations thereon to the head of the state department having jurisdiction over the institution examined;

(h) cause to be made from time to time, examinations and inspections of all labor camps and enforce the provisions of the sanitary code relating thereto;

(i) cause to be made, from time to time, examinations and inspections of all Indian reservations, and enforce all provisions of the sanitary code relating thereto.

(j) cause to be made such scientific studies and research which have for their purpose the reduction of morbidity and mortality and the improvement of the quality of medical care through the conduction of medical audits within the state. In conducting such studies and research, the commissioner is authorized to receive reports on forms prepared by him and the furnishing of such information to the commissioner, or his authorized representatives, shall not subject any person, hospital, sanitarium, rest home, nursing home, or other person or agency furnishing such information to any action for damages or other relief. Such information when received by the commissioner, or his authorized representatives, shall be kept confidential and shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits. Such information shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency, or person.

(k) notwithstanding any other provision of law, with the advice and assistance of the commissioner of agriculture and markets, establish rules and regulations to require such treatment of food or food products, including the addition or removal of specific substances, as may be necessary for the protection of the public health against the hazards of ionizing radiation.

(l) establish and operate such adult and child immunization programs as are necessary to prevent or minimize the spread of disease and to protect the public health. Such programs may include the purchase and distribution of vaccines to providers and municipalities, the operation of public immunization programs, quality assurance for immunization related activities and other immunization related activities. The commissioner may promulgate such regulations as are necessary for the implementation of this paragraph. Nothing in this paragraph shall authorize mandatory immunization of adults or children, except as provided in sections twenty-one hundred sixty-four and twenty-one hundred sixty-five of this chapter.

(m) make such rules and regulations which may be necessary to require pre-employment physical examination and thereafter require such annual examinations of all hospital employees for discovery of tuberculosis and other communicable diseases as he deems necessary for the safety and well being of the people of the state.

(n) by rule and regulation establish criteria for identification of areas and conditions involving high risk of lead poisoning, specify methods of detection of lead in dwellings, provide for the administration of prescribed tests for lead poisoning and the recording and reporting of the results thereof, and provide for professional and public education, as may be necessary for the protection of the public health against the hazards of lead poisoning.

(o) establish and publish a list of drug products, each of which shall meet the following conditions:

(1) The drug product has been certified or approved by the commissioner of the Federal Food and Drug Administration as being safe and effective for its labeled indications for use, and a new-drug application or an abbreviated new-drug application approved pursuant to the Federal Food, Drug, and Cosmetic Act is held for such drug product; and

(2) The commissioner of the Federal Food and Drug Administration has evaluated such drug product as:

(i) pharmaceutically and therapeutically equivalent and has listed such drug product on the list of approved drugs products with the therapeutic equivalence evaluations, provided, however, that the list prepared by the commissioner shall not include any drug product which

the commissioner of the Federal Food and Drug Administration has identified as having an actual or potential bioequivalence problem; or

(ii) as an interchangeable biological product and has listed such product on the list of approved drug products with interchangeability.

(p) promulgate rules and regulations establishing procedures to be used in implementing the provisions of article thirteen-E of this chapter as limited by section thirteen hundred ninety-nine-x of article thirteen-E of this chapter. Such rules and regulations shall include, but not be limited to, such matters as may be required to ensure that the established procedures thereunder shall at least be in compliance with the relevant provisions of the code of fair procedure set forth in section seventy-three of the civil rights law.

(q) have the authority to carry out the provisions of section one hundred seventy-seven-a of the navigation law.

* (r) shall prepare for publication, and cause to be distributed by general hospitals to patients upon inpatient admission, a booklet containing the information and materials required to be distributed to patients pursuant to this chapter and federal law. Where reasonable and appropriate, the booklet may summarize or describe information and materials required to be distributed to the patient, and how they may be obtained. The commissioner shall prepare and distribute to general hospitals physical, electronic or other materials from which the booklet can be produced. The commissioner shall revise and update such prepared booklet on a timely basis to reflect any changes in patient information and materials required to be distributed pursuant to law.

* NB There are 2 par. (r)'s

* (r) by rule and regulation, establish standards necessary and appropriate for the implementation of item (ii) of clause (a) of section three hundred twenty-two-c of the general business law. Such rules and regulations shall be approved by the New York state fire prevention and building code council.

* NB There are 2 par. (r)'s

(s) issue a readiness report to the legislature, detailing the status of the statewide health benefit exchange, state enrollment center, and state Medicaid enrollment center established under executive order number forty-two of two thousand twelve, by August thirtieth, two thousand thirteen. The readiness report may be provided in electronic

format and shall be distributed to the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on health, and the chair of the assembly health committee. The readiness report shall outline the progress and preparedness of the health benefit exchange, state enrollment center, and state Medicaid enrollment center and detail how the exchange, state enrollment center, and state Medicaid enrollment center will carry out their respective functions including but not limited to:

(i) the process by which the health benefit exchange, state enrollment center, and state Medicaid enrollment center will begin accepting applications on October first, two thousand thirteen;

(ii) the process by which the health benefit exchange, state enrollment center, and state Medicaid enrollment center will certify qualified health plans;

(iii) the anticipated cost of individual and small group plans being offered in the health benefit exchange;

(iv) the number of navigators approved;

(v) the plan for full operation by January first, two thousand fourteen; and

(vi) the plan to become fiscally self-sustaining by January first, two thousand fifteen.

(t) The department shall submit as part of its annual report prepared pursuant to section one hundred sixty-four of the executive law, which may be submitted in electronic format, comprehensive information including, but not limited to, a detailed description of the department's mission, priorities and goals for the upcoming year, achievements of the past year, and any relevant data and statistics.

(u) The commissioner shall provide a written or electronic copy of any state plan amendment submitted to the centers for Medicare and Medicaid services to the chair of the senate standing committee on health and the chair of the assembly health committee, no later than five business days from the date of mailing or submission.

* (v) require, in consultation and cooperation with the superintendent of financial services, that every individual applying for health care coverage through the state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education

Reconciliation Act of 2010 (P.L. 111-152), be provided space so that such applicant may register in the "donate life registry" for organ, eye and tissue donations under section forty-three hundred ten of this chapter with the following stated in clear conspicuous type:

"Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

The commissioner shall not maintain records of any person who checks "skip this question". Except where the application is made in person or electronically, failure to check a box shall not impair the validity of an application, and failure to check "yes" or checking "skip this question" shall not be construed to imply a wish not to donate. In the case of an applicant under eighteen years of age, checking "yes" shall not constitute consent to make an anatomical gift or registration in the donate life registry. Where an applicant has previously consented to make an anatomical gift or registered in the donate life registry, checking "skip this question" or failing to check a box shall not impair that consent or registration.

* NB Effective until December 21, 2026

* (v) require, in consultation and cooperation with the superintendent of financial services, that every individual applying for health care coverage through the state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), be provided space so that such applicant may register in the "donate life registry" for organ, eye and tissue donations under section forty-three hundred ten of this chapter with the following stated in clear conspicuous type:

"Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

The commissioner shall not maintain records of any person who checks "skip this question". Except where the application is made in person or electronically, failure to check a box shall not impair the validity of an application, and failure to check "yes" or checking "skip this question" shall not be construed to imply a wish not to donate. In the case of an applicant under eighteen years of age, checking "yes" shall

not constitute consent to make an anatomical gift or registration in the donate life registry, except as otherwise provided pursuant to the provisions of paragraph (b) of subdivision one of section forty-three hundred one of this chapter. Where an applicant has previously consented to make an anatomical gift or registered in the donate life registry, checking "skip this question" or failing to check a box shall not impair that consent or registration.

* NB Effective December 21, 2026

* NB There are 2 par (v)'s

* (v) by rule and regulation, cause the distribution of crib safety information. (1) The commissioner shall require that every hospital and birth center distribute at the time of discharge directly to each maternity patient and, upon request, to the general public an informational leaflet concerning crib safety. Such leaflet shall be designed by the commissioner in conjunction with the director of the division of consumer protection, on behalf of the consumer protection division, and shall contain information detailing safe sleeping procedures for babies, crib product recalls and disclosure of the federal standards on the manufacture and sale of cribs.

(2) Such leaflet shall be made available to hospitals and birth centers by the department on its website and shall be provided in English, as well as the top six languages other than English spoken in the state according to the latest available data from the United States Bureau of Census.

(3) Hospital staff shall inquire whether the maternity patient has a new crib available for any newborns. If the maternity patients do not have a new crib available, hospital staff shall provide information about where to obtain a new crib, including social services agencies, non-profit service providers or other relevant organizations.

* NB There are 2 par (v)'s

* (w) require that every electronic health record vendor include and integrate components into their electronic health record products implemented for general hospitals in the state regulated under article twenty-eight of this chapter in such a manner to allow patients to register directly in the New York state "donate life registry" for organ, eye and tissue donations as provided for under section forty-three hundred ten of this chapter. Such registration shall be via

a patient-facing portal, provided that, to protect patient confidentiality and prevent conflicts of interest, such electronic health record products do not retain or store patients' donor status information, and provided, further, that such electronic health record products meet standards as may be established by the commissioner, including, but not limited to, a standardized question allowing direct enrollment in the donate life registry and required data elements. Electronic health record vendors shall provide the integration of such elements without additional cost under this paragraph as a component of either existing or new implementations of their electronic health record products. Patient facing elements of these products shall include opportunities for patients to directly register in the "donate life registry" for organ, eye and tissue donations as a component of such elements.

* NB Effective December 21, 2026

2. The commissioner and any person authorized by him so to do, may, without fee or hindrance, enter, examine and survey all grounds, erections, vehicles, structures, apartments, buildings and places.

3. The commissioner may, on behalf and in the interest of the health of the people of the state enter into such contracts or agreements with individuals, colleges, universities, associations, corporations, municipalities and other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of the public health law and the sanitary code. Such contracts may provide for payment by the state, within the limit of funds available, for materials, equipment or services.

4. The commissioner may:

(a) issue subpoenas, compel the attendance of witnesses and compel them to testify in any matter or proceeding before him, and may also require a witness to attend and give testimony in a county where he resides or has a place of business without the payment of any fees;

(b) annul or modify an order, regulation, by-law or ordinance of a local board of health concerning a matter which in his judgment affects the public health beyond the territory over which such local board of

health has jurisdiction;

(c) assess any penalty prescribed for a violation of or a failure to comply with any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto, not exceeding two thousand dollars for every such violation or failure, which penalty may be assessed after a hearing or an opportunity to be heard;

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

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

5. Subject to the provisions of the state finance law, the commissioner is authorized to take, and administer for the state any grant, gift or bequest to be applied, principal or income or both, for the purposes specified in such grant, to the maintenance and use of any hospital, institution or service in the department.

6. The commissioner may enter into contracts:

(a) with corporations duly licensed in the state of New York to transact the business of accident and health insurance to provide to sick and disabled persons insured by them such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by them;

(b) with hospital service corporations organized and operating in accordance with article forty-three of the insurance law to provide to their subscribers nursing service and such other paramedical services as would have been available in a hospital (excluding physicians' services)

at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services;

(c) with any municipal corporation or local, state or federal agency to provide such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by sick and disabled persons;

(d) with medical expense indemnity corporations organized and operating in accordance with article forty-three of the insurance law to provide their subscribers with such home care, including nursing and other paramedical services, as may be needed by them at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services; and

(e) with any non-profit corporation, agency or association established for the purpose of improvement of health services or for the purpose of providing home care for sick and disabled persons, including nursing and other paramedical services (excluding physicians' services) as may be needed by such persons.

Such services may be provided by the state health commissioner by subcontract with a city or county rendering nursing and other paramedical services or any non-profit corporation, agency or association established for the purpose of the improvement of health services or for the purpose of providing home care for sick and disabled persons including nursing and other paramedical services (excluding physicians' services).

The state health commissioner shall establish the fees to be charged for such services to be rendered pursuant to such contracts and, upon receipt of such fees, shall remit the same to the comptroller.

7. The commissioner may establish fees for nursing and other paramedical services (excluding physicians' services) rendered to people sick at home.

Such services may be provided by the state health commissioner or by subcontract with a city or county rendering nursing and other paramedical services or any non-profit corporation, agency, or

association established for the purpose of the improvement of health services or for the purpose of providing home care for sick and disabled persons including nursing and other paramedical services (excluding physicians' services).

8. Whenever, in this chapter, the commissioner is empowered to or charged with the responsibility to do or perform any act, he may deputize in writing any officer or employee in the department to do or perform the act in his place and stead.

9. The commissioner may deputize in writing any local health officer to do or perform in his place and stead those duties and responsibilities charged upon the commissioner by paragraphs (d), (g), (h) and (i) of subdivision one of this section, those duties of inspection and enforcement charged upon the commissioner by paragraph f of subdivision three of section six thousand five hundred fifty-eight of the education law and those duties of inspection and supervision charged upon the department by paragraphs (m), (n), (r) and (s) of subdivision one of section two hundred one of this chapter; provided, however, in the city of New York such deputization shall be subject to the prior approval of the mayor of such city.

10. The commissioner, with the approval of the state director of the budget, shall establish and promulgate a schedule of proportional shares for cost sharing under subdivision one of section three hundred sixty-nine-d of the social services law. In developing such a schedule, the commissioner shall take into consideration various options available for obtaining health care services, the availability of such services, and the impact of cost sharing on prudent utilization and efficient provision of services without undue barriers to care for persons eligible for assistance under the catastrophic health care expense program established by section three hundred sixty-nine-c of the social services law.

11. The commissioner shall cooperate with the commissioner of the state department of environmental conservation, district attorneys and the department of law in providing assistance in the investigation and

prosecutions of violations of article twenty-seven of the environmental conservation law.

* 12. (a) The commissioner shall establish and assess a regulatory assessment fee which will be charged to providers of health-care services regulated by the department under the provisions of articles twenty-eight, thirty-six and forty-four of this chapter, including health maintenance organizations established pursuant to article forty-three of the insurance law. The level of such regulatory fees shall be sufficient to recover the costs related to regulating such providers and costs related to the establishment and auditing of rates of reimbursement for the state fiscal year ending during the annual period in which such fee shall be assessed. Such costs will be certified by the director of the budget to the commissioner and shall include direct and indirect costs. The commissioner, subject to the approval of the director of the budget, shall develop a means of distributing the assessment of such a fee among the affected health-care providers based upon each provider's proportionate share of the sum of total costs and revenues reported for all such providers. For the purposes of this section, the sum of total costs and revenues shall be calculated by including, for the most recent annual period for which certified data is available, total reported costs of a facility except that amounts included for general hospital outpatient and emergency services and treatment or diagnostic center services shall be based upon reported, or in its absence, estimated revenues, and costs included for article forty-four providers, and article forty-three providers of the insurance law shall exclude costs associated with the purchase of inpatient services.

(b) The fees assessed pursuant to this subdivision shall be deemed allowable operating costs in the determination of reimbursement rates and charges established pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law. The costs incurred for this purpose during a given rate year shall be included in the respective reimbursement rates for each such year. Charges established pursuant to subdivisions six and thirteen of section twenty-eight hundred seven-a of this chapter shall also be permitted to increase to include the annual costs associated with the assessment of such fee. The cost of such fee shall not be subject to reimbursement

ceilings or other penalties used by the commissioner for the purpose of establishing rates of reimbursement pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law. Whenever an adjustment in such fees is made, reimbursement rates shall also be adjusted to include the increase or decrease in costs associated with such assessment fee.

(c) There is hereby created and established in the joint custody of the comptroller and the commissioner of taxation and finance an account to be known as the health care regulatory account. Notwithstanding section one hundred twenty-one of the state finance law or any other law to the contrary, the commissioner shall pay to the state treasurer for deposit into such account any revenues received from the regulatory fee or amounts withheld pursuant to paragraph (d) of this subdivision. The commissioner shall establish by regulation a schedule of payments which to the extent practicable shall reflect the timeliness of reimbursement received by providers for the cost of such fee and define timely payments of the regulatory assessment fee for the purposes of implementing paragraph (d) of this subdivision. Payments established pursuant to this paragraph shall not be due until reimbursement rates established pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law are adjusted to include the annual cost of such fee. The fee may be adjusted by the commissioner at any time, but in no event shall the fees exceed the amount appropriated for transfer to the general fund from the health care regulatory account.

(d) Upon receipt of notification from the commissioner or the director of the budget, the comptroller or a fiscal intermediary designated by the director of the budget shall withhold from the amount of any payment to be made by the state to a provider enumerated in paragraph (a) of this subdivision the amount of such arrearage resulting from such provider's failure to make a timely payment of the regulatory assessment fee in accordance with the schedule promulgated by the commissioner. Upon withholding such amount, the comptroller or a designated fiscal intermediary shall pay the commissioner such amount withheld.

* NB (Effective pending Federal Government Ruling)

* 13. (a) The commissioner shall establish and assess a fee which will be charged to providers of health-care services regulated by the

department under the provisions of articles twenty-eight, thirty-six and forty-four of this chapter, including health maintenance organizations established pursuant to article forty-three of the insurance law. The level of such fee shall be sufficient to recover the costs of making grants to health systems agencies and to match other contributions pursuant to subdivision (g) of section two thousand nine hundred four-b of this chapter (the health systems agency fee). The commissioner, subject to the approval of the director of the budget, shall develop a means of distributing the assessment of the fee among the affected health-care providers based upon each provider's proportionate share of the sum of total costs and revenues reported for all such providers. For the purposes of this section, the sum of total costs and revenues shall be calculated by including, for the most recent annual period for which certified data is available, total reported costs of a facility except that amounts included for general hospital outpatient and emergency services and treatment or diagnostic center services shall be based upon reported, or in its absence estimated revenues, and costs included for article forty-four providers and article forty-three providers of the insurance law, shall exclude costs associated with the purchase of inpatient services. The fee shall not exceed one-tenth of one percent of the total costs or revenues reported by such provider. There is hereby created and established in the joint custody of the comptroller and the commissioner of taxation and finance an account to be known as the health systems agency account. Notwithstanding section one hundred twenty-one of the state finance law, or any other law to the contrary, the commissioner shall pay to the state treasurer for deposit into such account any revenues received from the health systems agency fees or amounts withheld pursuant to paragraph (c) of this subdivision for health systems agency fee obligations into the health systems agency account. The monies deposited to the health systems agency account shall be used to make grants to health systems agencies pursuant to subdivision (f) of section twenty-nine hundred four-b of this chapter and to match contributions pursuant to subdivision (g) of section two thousand nine hundred four-b of this chapter. The commissioner shall establish by regulation a schedule of payments which to the extent practicable shall reflect the timeliness of reimbursement received by providers for the cost of such fee and a definition of timely payments

for the purposes of implementing paragraph (c) of this subdivision. No payment shall be due until reimbursement rates established pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law are adjusted to include the costs of the fee. The fee may be adjusted by the commissioner at any time, but in no event shall the fees exceed the limitation set forth in this paragraph.

(b) The fees assessed pursuant to this subdivision shall be deemed allowable operating costs in the determination of reimbursement rates and charges established pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law. The costs incurred for this purpose during a given rate year shall be included in the respective reimbursement rates for each such year. Charges established pursuant to subdivisions six and thirteen of section twenty-eight hundred seven-a of this chapter shall also be permitted to increase to include the annual costs associated with the assessment of such fee. The cost of such fee shall not be subject to reimbursement ceilings or other penalties used by the commissioner for the purpose of establishing rates of reimbursement pursuant to articles twenty-eight, thirty-six and forty-four of this chapter and article forty-three of the insurance law. Whenever an adjustment in such fees is made, reimbursement rates shall also be adjusted to include the increase or decrease in costs associated with such fee.

(c) Upon receipt of notification from the commissioner or the director of the budget, the comptroller or a fiscal intermediary designated by the director of the budget shall withhold from the amount of any payment to be made by the state to a provider enumerated in paragraph (a) of this subdivision the amount of such arrearage resulting from such provider's failure to make a timely payment of the fee in accordance with the schedule promulgated by the commissioner. Upon withholding such amount, the comptroller or a designated fiscal intermediary shall pay the commissioner such amount withheld.

* NB (Effective pending Federal Government Ruling)

14. (a) Notwithstanding section one hundred twelve of the state finance law or any other provision of law to the contrary, the commissioner is authorized to establish a plan for the collection and

disbursement of clinical practice income resulting from the clinical practice of licensed health professionals employed by Roswell Park Cancer Institute.

(b) For the purposes of this subdivision the following words shall have the following meanings:

(i) "clinical practice" means providing all forms of medical and health care, including patient consultations, and performing clinical investigation involving patients, at or through Roswell Park Cancer Institute, for which acts a fee for professional service is customarily charged.

(ii) "clinical practice income" means the income from fees for services of licensed health professionals rendered in connection with clinical practice.

(iii) "clinical practice plan" means a facility-based plan established to provide for the management, including collection and disbursement, of clinical practice income, subject to direction by a facility-based governing board.

(c) The commissioner is authorized to promulgate such rules and regulations as may be necessary to implement the provisions of this subdivision. Such rules shall include, but not be limited to, criteria for participation in the clinical practice plan, including who contributes and who may receive income from the plan, the purposes for which such income may be disbursed, the maximum allowable compensation, the fringe benefits provided by the plan, provision for an accounting system for recording all receipts and disbursements of fees received, and provision for fiscal reports to the commissioner and an annual audit of such accounts by the state and/or an independent auditor.

Notwithstanding any law, rule or regulation to the contrary, the commissioner may determine the fringe benefits to be provided to the clinical practice plan members from clinical practice income and may authorize the expenditure of clinical practice income for this purpose or to supplement fringe benefits provided from state appropriations.

(d) Any clinical practice plan established pursuant to this subdivision shall not restrict the authority of the comptroller in paragraph (c) of subdivision two of section four hundred nine of this chapter to maintain at all times on deposit in the department of health

income fund established pursuant to section four hundred nine of this chapter the aggregate amount of money needed by the department during six calendar months to comply in full with all obligations of the department under the terms of every lease, sublease, or agreement of the department with the dormitory authority which is then in effect.

(e) Employees with a faculty appointment participating in a clinical practice plan at Roswell Park Cancer Institute established pursuant to subdivision fourteen of section two hundred six of this chapter who are eligible to participate in the New York state employees' retirement system may elect, within ninety days of becoming eligible to participate in such system, in lieu of participating in such system, to participate in the optional retirement program available to employees of the state university of New York pursuant to article eight-B of the education law, subject to the terms and conditions of that article and to the provisions of the retirement and social security law.

* 15. Notwithstanding any other provision of law to the contrary, the commissioner is authorized to establish a statewide in-line skate, skate board, and bicycle helmet public education and awareness program and a statewide in-line skate, skate board, and bicycle helmet distribution program. The purpose of the statewide in-line skate, skate board, and bicycle helmet public education and awareness program is to provide a plan for the coordination of county, city, town and village efforts to reduce in-line skate, skate board, and bicycle related injuries and fatalities. The purpose of the statewide in-line skate, skate board, and bicycle helmet distribution program is to provide a plan for the coordination of county, city, town and village efforts to distribute helmets to persons who can demonstrate an economic hardship that precludes them from purchasing such helmet. The commissioner shall make all necessary efforts to ensure that an in-line skate, skate board, and bicycle helmet distribution program is instituted in each county of the state. The commissioner is authorized to promulgate such rules and regulations as may be necessary to implement the provisions of this subdivision.

* NB There are 3 sub. 15's

* 15. (a) The commissioner shall promulgate rules and regulations which establish:

(i) procedures to review and approve rape crisis programs that provide

training to rape crisis counselors as defined in section four thousand five hundred ten of the civil practice law and rules;

- (ii) minimum training standards for rape crisis counselors;

- (iii) procedures to enable approved rape crisis programs to certify current and future rape crisis counselors, including volunteer counselors, provided such rape crisis counselors have met the minimum training standards as set forth in this subdivision; and

- (iv) procedures to periodically review approved training programs to assure they continue to satisfy established standards.

(b) Rape crisis programs approved by the commissioner shall provide training programs consisting of at least thirty hours of pre-service training and within the first year of service at least ten hours of in-service training for rape crisis counselors. This training shall include but not be limited to, instruction on the following:

- (i) the dynamics of sexual offenses, sexual abuses or incest;

- (ii) crisis intervention techniques;

- (iii) client-counselor confidentiality requirements;

- (iv) communication skills and intervention techniques;

- (v) an overview of the state criminal justice system;

- (vi) an update and review of state laws on sexual offenses, sexual abuse or incest;

- (vii) the availability of state and community resources for clients;

- (viii) working with a diverse population;

- (ix) an overview of child abuse and maltreatment identification and reporting responsibilities; and

- (x) information on the availability of medical and legal assistance for such clients.

(c) The department shall provide technical assistance to approved rape crisis programs to implement training programs in accordance with the minimum standards set forth in this subdivision.

* NB There are 3 sub. 15's

* 15. The commissioner is authorized to make grants and enter into contracts, as recommended by the state task force on clinical practice guidelines and medical technology assessment established pursuant to section twenty-eight hundred four-a of this chapter, for research and/or projects to promote the identification, evaluation, development and/or application of clinical practice guidelines and appropriate use of

medical technology, but in no way to direct or mandate the use of such guidelines or technology, to the extent of funds available therefor from the commissioner's priority distributions pursuant to subparagraph (ii) of paragraph (f) of subdivision nineteen of section twenty-eight hundred seven-c of this chapter. No grants or contracts executed pursuant to this section shall be for the purpose of developing clinical practice guideline based reimbursement methodologies or any other regulations. For the purposes of this subdivision, "clinical practice guidelines" shall mean systematically developed statements to assist physician and patient decisions about the appropriate health care for specific clinical circumstances, and "medical technology" shall mean an instrument or unit of equipment or technique for use as a health related treatment, testing or diagnostic tool.

* NB Expired June 30, 1996; There are 3 sub. 15's

16. The commissioner, in consultation with the commissioner of the department of motor vehicles, shall promulgate rules and regulations specifying the medical conditions based on health and safety which justify granting an exception to the requirements of subparagraphs one and two of paragraph (b) of subdivision twelve-a of section three hundred seventy-five of the vehicle and traffic law.

* 17. (a) The commissioner shall enter into an agreement with the commissioner of taxation and finance which shall set forth the procedures for the crediting of overpayments of tax owed to an individual taxpayer, estate or trust to the repayment of overpayments of medical assistance payments owed to the department or a social services district by such person pursuant to the provisions of section one hundred seventy-one-f of the tax law and is authorized to furnish to the commissioner of taxation and finance such information and to take such other actions as may be necessary to carry out the agreement provided for in such section, for the crediting of overpayments of tax to repayment of overpayments of medical assistance payments received by an individual who is or has been enrolled as a provider in the New York state medical assistance program as established under title eleven of article five of the social services law.

(b) The department shall by regulation establish procedures by which any individual, estate or trust which is the subject of a certification

to the department of taxation and finance in accordance with such agreement may contest such certification. Such regulations and the notice required by subdivision three of section one hundred seventy-one-f of the tax law shall set forth defenses which may be available to the individual, estate or trust to contest such certification and the manner in which a review of the certification based on such defenses may be obtained.

(c) In accordance with such agreement and the provisions of section one hundred seventy-one-f of the tax law, the department shall be entitled to receive payments to satisfy the payment obligation of a person who is receiving or has received payment as a provider in the New York state medical assistance program established under title eleven of article five of the social services law, in accordance with a written final determination of the department, provided that a proceeding for administrative or judicial review shall not be pending and the time for initiation of such proceedings shall be expired.

* NB There are 2 sub. 17's

* 17. The department, upon completion of a review of the existing scientific research regarding allergic reactions to natural rubber latex products, shall issue guidelines, in consultation with health care providers, for a latex management program, in health care settings.

* NB There are 2 sub. 17's

* 18. The commissioner is authorized and directed to promulgate rules and regulations to establish standards for water wells, including but not limited to drilling, construction, abandonment, repair, maintenance, water flow, including testing thereof, and pump standards for such wells.

* NB There are 2 sub. 18's

* 18. The commissioner, subject to the approval of the director of the budget, is authorized to approve and implement medicaid demonstration programs designed to provide additional knowledge and experience and to collect information concerning alternative methodologies for reimbursement, delivery of medical services, or eligibility for medical assistance in hospice operated nursing homes and is further authorized to waive such provisions of article twenty-eight of this chapter and title eleven of article five of the social services law as are necessary to implement such demonstration programs when such waiver will promote

the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of patients will not be impaired as a result of such waiver.

* NB There are 2 sub. 18's

18-a. Health information technology demonstration program. (a) (i) The commissioner is authorized to issue grant funding to one or more organizations broadly representative of physicians licensed in this state, from funds made available for the purpose of funding research and demonstration projects under subparagraph (ii) of this paragraph designed to promote the development of electronic health information exchange technologies in order to facilitate the adoption of interoperable health records.

(ii) Project funding shall be disbursed to projects pursuant to a request for proposals based on criteria relating to promoting the efficient and effective delivery of quality physician services. Demonstration projects eligible for funding under this paragraph shall include, but not be limited to:

- (A) efforts to incentivize electronic health record adoption;
- (B) interconnection of physicians through regional collaborations;
- (C) efforts to promote personalized health care and consumer choice;
- (D) efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring.

(iii) The department shall issue a report to the governor, the temporary president of the senate and the speaker of the assembly within one year following the issuance of the grants. Such report shall contain, at a minimum, the following information: the demonstration projects implemented pursuant to this paragraph, their date of implementation, their costs and the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state.

* (b) The commissioner shall:

(i) post on its website by September first, two thousand fifteen and quarterly thereafter, information on the uses of funding in support of the Statewide Health Information Network of New York (SHIN-NY), including how such funds may be used to:

(A) support hospitals, physicians, and other providers in the achievement of federal meaningful use requirements;

(B) support DSRIP health information exchange and data requirements to help performing provider systems and the state meet DSRIP quality goals; and

(C) increase participation in regional health information organizations by providers at reasonable costs to the providers; and

(ii) convene a workgroup to:

(A) evaluate the state's health information technology infrastructure and systems, as well as other related plans and projects designed to make improvements or modifications to such infrastructure and systems including, but not limited to, the all payor database (APD), the state planning and research cooperative system (SPARCS), regional health information organizations (RHIOs), the statewide health information network of New York (SHIN-NY) and medical assistance eligibility systems; and

(B) develop recommendations for the state to move toward a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security;

(iii) submit an interim report to the governor, the temporary president of the senate and the speaker of the assembly, which shall detail the concerns and issues associated with establishing the state's health information technology infrastructure considered by the workgroup, on or before December first, two thousand fourteen; and

(iv) submit a report to the governor, the temporary president of the senate and the speaker of the assembly, which shall fully consider the evaluation and recommendations of the workgroup, on or before December first, two thousand fifteen.

* NB Effective until March 31, 2029

* (b) The commissioner shall make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a statewide health information network of New York (SHIN-NY) to enable widespread interoperability among disparate health

information systems, including electronic health records, personal health records and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY.

* NB Effective March 31, 2029

(c) The members of the workgroup shall include, at a minimum, three members who represent RHIIOs, two members employed by the department who are involved in the development of the SHIN-NY and the APD, two members who represent physicians, two members who represent hospitals, two members who represent home care agencies, one member who represents federally qualified health centers, one member who represents county health commissioners, the chair of the senate health committee or his or her designee, the chair of the assembly health committee or his or her designee, and other individuals with expertise in matters relevant to the charge of the workgroup.

* (d) The commissioner may make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a self-sufficient SHIN-NY to enable widespread, non-duplicative interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, payment and other administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY or any other statewide health information system recommended by the workgroup. If the commissioner seeks to promulgate rules and regulations prior to issuance of the report identified in subparagraph (iv) of paragraph (b) of this subdivision, the commissioner shall submit the proposed regulations to the workgroup for its input. If the commissioner seeks to promulgate rules and regulations after the issuance of the report identified in such subparagraph (iv) then the commissioner shall consider the report and recommendations of the workgroup. If the commissioner acts in a manner inconsistent with the input or recommendations of the workgroup,

he or she shall provide the reasons therefor.

* NB Effective until March 31, 2029

* 19. The commissioner is authorized and directed to promulgate rules and regulations as may be necessary, with respect to the form and content of applications for licenses, the fees to be charged for obtaining licenses, permits, duplicates and renewals, the reception thereof, the investigation and examination of applicants and of prospective applicants taking examinations and their qualifications, the inquiry into the operation of body piercing or tattooing studios and the conducting of periodic inspection of facilities to determine compliance by the tattoo or body piercing studio with applicable statutes, rules and regulations, appropriate penalties for failure to abide by rules and regulations promulgated pursuant to this article, and additional visits that may be made to tattoo or body piercing studios to determine whether violations or deficiencies have been corrected, to investigate any complaint, and for any other purposes deemed necessary and appropriate by the commissioner. Such regulations shall include, but not be limited to, the hygienic requirements for sterilization of sharps, needles, and other supplies and equipment, the general cleanliness of the body piercing studio or tattoo studio, the disposal of each sharp and other single use supplies after use on one customer, the proper disposal of contaminated supplies and equipment, and other matters incidental or appropriate to the powers and duties of the commissioner as prescribed by this subdivision and for the proper administration and enforcement of the provisions of this subdivision to ensure the health, safety and welfare of the public.

* NB There are 2 sub. 19's

* 19. (a) The commissioner shall ensure that any contracts entered into, renewed, extended, modified or in any way made or continued with entities pursuant to article twenty-eight of this chapter to receive, distribute and otherwise administer funds for the pools specified in this subdivision, require such pool administrators to submit directly to the temporary president of the senate and the speaker of the assembly quarterly reports on the collection, pooling and distribution of funds pursuant to the following sections of this chapter:

(i) paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c of this chapter, providing for a one percent assessment

on hospital revenues;

(ii) section twenty-eight hundred seven-j, establishing allowances on net patient service revenues;

(iii) section twenty-eight hundred seven-k, establishing the general hospital indigent care pool;

(iv) section twenty-eight hundred seven-l, establishing the health care initiatives pool;

(v) section twenty-eight hundred seven-m, establishing regional professional education pools;

(vi) section twenty-eight hundred seven-s, establishing professional education pool funding;

(vii) section twenty-eight hundred seven-t, establishing assessments on covered lives; and

(viii) section twenty-eight hundred seven-v, establishing tobacco control and insurance initiatives pool.

The commissioner shall assist such pool administrators, as necessary, in the fulfillment of this requirement.

(b) Reports filed pursuant to paragraph (a) of this subdivision shall, at a minimum, for each quarterly period

(i) profile, as of the end of each quarter and based on the available data, all revenue collected pursuant to each source specified in subparagraphs (i), (ii), (vi) and (vii) of paragraph (a) of this subdivision, as well as revenue collected for deposit into the pools specified in subparagraph (viii) of such paragraph, further reported, as applicable, according to each category of payer, including, but not limited to, medical assistance, private insurance, employer benefit plans, workers' compensation, no-fault, cigarette taxes, tobacco settlement funds, and the public asset established pursuant to sections four thousand three hundred one and seven thousand three hundred seventeen of the insurance law;

(ii) profile, as of the end of each quarter and based on the available data, aggregate revenue, by source, deposited for the quarter, into each pool specified in subparagraphs (iii), (iv), (v), and (viii) of paragraph (a) of this subdivision as well as the fund balances for each such pool as of the end of each quarter; and

(iii) profile, as of the end of each quarter and based on the

available data, every disbursement from each pool specified in subparagraphs (iii), (iv), (v) and (viii) of paragraph (a) of this subdivision, further reported, as applicable, according to and indicative of each allocation specified for such pool, and further reported according to and indicative of each recipient of funds from each such allocation, except allocations made pursuant to subparagraph (iii) of paragraph (c) of subdivision one of section twenty-eight hundred seven-1 of this chapter, and further indicative of the status of funding for each such recipient.

(c) The reports required by paragraph (a) of this subdivision shall cover the periods January through March, April through June, July through September and October through December and shall be submitted no later than forty-five days following the last day of the quarterly period covered by the report. Reports shall be submitted in both written and electronic form.

(d) The commissioner shall also ensure that any such contracts require such entities, beginning August first, two thousand three and no later than the twelfth day of each month thereafter, to report to the comptroller in an electronic and written format the beginning pool balances, receipts collected by source, the disbursements made by purpose, the amount and nature of any transfers made among such pools, and the ending pool balances for the pools described in subparagraphs (i), (ii) and (iii) of paragraph (b) of this subdivision and at the same level of specificity required by such paragraph. The comptroller shall include such information in the monthly report required by subdivision nine-a of section eight of the state finance law. Any additional expenses incurred by the entity as a result of this paragraph shall be borne by the department of health.

* NB There are 2 sub. 19's

20. The commissioner shall, in consultation with the superintendent of state police, promulgate, by regulation, a list of "select chemical agents" which shall consist only of those toxic chemicals which have been identified, as of the effective date of this subdivision, for the application of verification measures under article VI of the convention on the prohibition of the development, production, stockpiling and use of chemical weapons and on their destruction, opened for signature on

January thirteenth, nineteen hundred ninety-three, in schedules contained in the annex to said convention. The commissioner may, from time to time, promulgate regulations amending said list in the event that the schedules contained in the annex to the convention are amended, revised, modified or repealed, so that the list of select chemical agents promulgated pursuant to this subdivision conforms in whole or in part to any such amended, revised, modified or repealed list, if the commissioner determines that any such amendment, revision, modification or repeal is consistent with the purposes of this chapter.

* 21. The commissioner shall, in consultation with the superintendent of state police, promulgate, by regulation, a list of "select biological agents" which shall consist only of those select biological agents which have been identified, as of the effective date of this subdivision, by the United States Secretary of Health and Human Services and placed on the select agent list established pursuant to section 511 (d) of the Antiterrorism and Effective Death Penalty Act, Pub. L. 104-132 at 42 C.F.R. Part 72. The commissioner may, from time to time, promulgate regulations amending said list in the event that the list of select biological agents promulgated by federal regulations is amended, revised, modified or repealed, so that the list of select biological agents promulgated pursuant to this subdivision conforms in whole or in part to any such amended, revised, modified or repealed list, if the commissioner determines that any such amendment, revision, modification or repeal is consistent with the purposes of this chapter.

* NB There are 2 sub 21's

* 21. The commissioner shall make the information developed pursuant to section five hundred forty-four of the executive law available through, but not limited to, the department's website and written materials available to the public.

* NB There are 2 sub 21's

22. The commissioner shall provide information and technical assistance concerning the drug discount program authorized by section 340B of the federal public health service act (42 U.S.C § 256b) to:

(a) covered entities, as defined in section 340B of the public health service act, to facilitate their participation in such drug discount program; and

(b) local government officials, regarding the benefits of the drug discount program and the process of accessing discounted drugs under the program on behalf of individuals whose prescription drug costs are borne by local government, including but not limited to residents of county-operated nursing homes.

23. Pursuant to subdivision six of section two hundred two of the state administrative procedure act, on an emergency basis and upon a finding by the commissioner of an immediate threat to the public safety, the commissioner is authorized to remove a drug, procedure or supply whose primary purpose is to enhance or facilitate sexual performance from: (a) the definition of medical assistance established pursuant to section three hundred sixty-five-a of the social services law, (b) the definition of health care services covered by the family health plus program established pursuant to section three hundred sixty-nine-ee of the social services law, (c) the definition of covered health services established pursuant to subdivision seven of section twenty-five hundred ten of this chapter, or (d) the list of prescription drugs covered by the program for elderly pharmaceutical insurance coverage (EPIC) established pursuant to title three of article two of the elder law, or to otherwise restrict the criteria for payment for such drug, procedure or supply, by the medicaid, family health plus, child health plus, or EPIC programs, for those persons required to register as sex offenders pursuant to article six-C of the correction law.

* 24. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is authorized to receive applications and to determine initial and continuing eligibility for enrollment under the child health plus program established under title I-A of article twenty-five of this chapter, the medical assistance program established under title eleven of article five of the social services law, and the family health plus program established under title eleven-D of such article. The commissioner may exercise such authority with respect to all residents, or a subset of residents, of one or more local social services districts. The commissioner is authorized to enter into one or more contracts, which contracts shall be procured on a competitive basis pursuant to a request for proposal process, for the purpose of exercising his or her authority under this subdivision. State employees

shall supervise and provide oversight and quality assurance monitoring of contract staff activities. Provided further, the department shall endeavor to use state employees in exercising the commissioner's authority under this subdivision.

* NB There are 2 sb 24's

* 24. The commissioner shall have the authority to correct errors on marriage certificates maintained by the department pursuant to paragraph (e) of subdivision one of this section upon request of any applicant whose name appears thereon for a certificate of marriage where:

(a) such error was not the result of any intended fraud, deception or attempt to avoid the effect of any valid law, regulation or statute; and

(b) either party to the marriage provides proof, satisfactory to the commissioner, of the accuracy of the facts presented in support of correcting the error.

To effectuate such correction and provide certified copies of the amended certificate, the commissioner shall be entitled to a fee not exceeding ten dollars. The commissioner shall forward a copy of such amended certificate to the clerk of the town or city which issued such certificate.

* NB There are 2 sb 24's

25. (a) In assessing and reporting on the impact of section sixty-eight hundred one of the education law, pursuant to subdivision four of such section the commissioner may use: (1) influenza vaccine supply data from the federal centers for disease control and prevention; (2) pneumococcal vaccine supply data provided by manufacturers and distributors of such vaccine; and (3) data from a third party entity that engages in the collection of data and tracking of pharmaceutical sales and distribution. Manufacturers and distributors of pneumococcal vaccine shall provide or arrange for the timely provision to the commissioner of such data as the commissioner may reasonably request to complete the report. Provider and customer identifiable information submitted pursuant to this paragraph shall be confidential, unless the information provider consents to its release or the commissioner determines disclosure is necessary to respond to an imminent public health emergency.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, the commissioner may require reporting by entities licensed pursuant to article twenty-eight or thirty-six of this chapter, pharmacies registered pursuant to article one hundred thirty-seven of the education law, manufacturers and distributors of adult immunizing agents doing business in this state, and others possessing such adult immunizing agents of additional information needed to respond to an imminent public health emergency.

26. The commissioner is hereby authorized and directed to review any policy or practice instituted in facilities operated by the department of corrections and community supervision, and in all local correctional facilities, as defined in subdivision sixteen of section two of the correction law, regarding human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), hepatitis C (HCV), and COVID-19, including the prevention of the transmission of and the treatment of such infections and diseases among incarcerated individuals. Such review shall be performed at least annually, and shall focus on whether such policy or practice is consistent with current, generally accepted medical standards and procedures used to prevent the transmission of and to treat those infections and diseases among the general public. In performing such reviews, in order to determine the quality and adequacy of care and treatment provided, department personnel are authorized to enter correctional facilities and inspect policy and procedure manuals and medical protocols, interview health services providers and incarcerated individual-patients, review medical grievances, and inspect a representative sample of medical records of incarcerated individuals known to be infected with any such infections or diseases. Prior to initiating a review of a correctional system, the commissioner shall inform the public, including patients, their families and patient advocates, of the scheduled review and invite them to provide the commissioner with relevant information. Upon the completion of such review, the department shall, in writing, approve such policy or practice as instituted in facilities operated by the department of corrections and community supervision, and in any local correctional facility, or, based on specific, written recommendations, direct the department of corrections and community supervision, or the authority

responsible for the provision of medical care to incarcerated individuals in local correctional facilities to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The commissioner shall monitor the implementation of such corrective plans and shall conduct such further reviews as the commissioner deems necessary to ensure that identified deficiencies in those policies and practices are corrected. All written reports pertaining to reviews provided for in this subdivision shall be maintained, under such conditions as the commissioner shall prescribe, as public information available for public inspection.

27. The commissioner shall promulgate regulations to require that a manufacturer or other entity selling, leasing, or otherwise providing any drug, device, or health care service shall not, directly or indirectly, establish as a condition for the use by a dentist of such drug, device, or health care service that the dentist meet any quota for the number of patients on whom the dentist uses the drug, device, or health care service and that a dentist shall not, directly or indirectly, request or receive from any manufacturer or other entity a drug, device, or health care service having a condition that the dentist meet any quota for the number of patients on whom the dentist uses the drug, device, or health care service.

28. The commissioner shall assist the commissioner of education in developing rules and regulations, relating to pupils who suffer mild traumatic brain injuries and the physicians and nurse practitioners authorized to evaluate such pupils, in accordance with subdivision forty-two of section three hundred five of the education law, and provide for the posting on the department's internet website of such information as shall be required pursuant to such subdivision.

* 30. The commissioner shall notify the commissioner of education in any instance in which a registered professional nurse engages in improper behavior while supervising an advanced home health aide pursuant to subdivision two of section sixty-nine hundred eight of the education law.

* NB Repealed March 31, 2029

31. The commissioner shall develop information, in conjunction with the commissioner of education related to students who exhibit signs or symptoms of pending or increased risk of sudden cardiac arrest. Such information shall include, but not be limited to, the definition of sudden cardiac arrest, signs and symptoms of sudden cardiac arrest, and information for the physicians and nurse practitioners authorized to evaluate whether a student may resume athletic activity. Such information shall be posted on the department's website.

§ 206-a. Discrimination in hospital staff appointments and privileges prohibited. 1. It shall be an unlawful discriminatory practice for the governing body of a hospital

a. To deny to or to withhold from a physician, dentist or podiatrist staff membership or professional privileges in a hospital because of his participation in any medical group practice, non-profit health insurance plan, or comprehensive health services plan offered by a health maintenance organization authorized by the laws of the state; or

b. To exclude or to expel a physician, dentist or podiatrist from staff membership or to curtail, terminate or diminish in any way a physician's, dentist's or podiatrist's professional privileges in a hospital because of his participation in any medical group practice, non-profit health insurance plan, or comprehensive health services plan offered by a health maintenance organization authorized by the laws of the state.

2. Any person claiming to be aggrieved by an unlawful discriminatory practice defined by this section may, by himself or his attorney, make, sign and file with the commissioner a verified complaint in writing which shall state the name and address of the hospital whose governing body is alleged to have committed the unlawful discriminatory practice complained of and which shall set forth the particulars thereof and contain such other information as may be required by the commissioner.

3. After the filing of any such complaint, the commissioner shall designate a deputy commissioner or other officer of the department to make a prompt investigation in connection therewith; and if such designee shall determine after investigation that probable cause exists for crediting the allegations of the complaint, he shall immediately endeavor to eliminate the unlawful discriminatory practice by conference, conciliation and persuasion.

4. In case of a failure so to eliminate such practice, or in advance thereof as in his judgment circumstances so warrant, the commissioner shall cause to be issued a written notice together with a copy of the complaint, as the same may have been amended, requiring each member of the governing body of the hospital in question (or such member or members thereof as in his judgment are warranted), hereinafter sometimes referred to as respondent, to answer charges of such complaint at a hearing before him (or before a deputy commissioner or other officer of the department other than the designee who investigated the complaint), hereinafter referred to as hearing officer, at a time and place to be specified in such notice.

5. The respondent may file a written verified answer to the complaint and appear at such hearing in person or otherwise with or without counsel and submit testimony.

6. If, upon all the evidence at the hearing, the hearing officer shall find that a respondent has engaged in any unlawful discriminatory practice defined in this section, the hearing officer shall state his findings of fact and the commissioner shall issue and cause to be served on such respondent an order requiring such respondent to cease and desist from such unlawful discriminatory practice.

7. If, upon all the evidence at the hearing, the hearing officer shall find that a respondent has not engaged in any unlawful discriminatory practice defined in this section, the hearing officer shall state his findings of fact and the commissioner shall issue and cause to be served on the complainant an order dismissing the said complaint as to such respondent.

8. The commissioner shall establish rules of practice to govern, expedite and effectuate the foregoing procedure and the actions to be taken thereunder.

9. Any complaint filed pursuant to this section must be so filed within ninety days after the alleged act of discrimination.

10. Any complainant, respondent or other person aggrieved by such order of the commissioner may obtain judicial review thereof, and the commissioner may obtain an order of court for its enforcement, in a proceeding as provided in this subdivision. Such proceeding shall be brought in the supreme court of the state within any county wherein the unlawful discriminatory practice which is the subject of the commissioner's order occurs or wherein any person required in the order to cease and desist from a unlawful discriminatory practice resides or transacts business. The findings of the hearing officer as to the facts shall be conclusive if supported by substantial evidence on the record considered as a whole. All such proceedings shall be heard and determined by the court and any appellate court as expeditiously as possible and with lawful precedence over other matters.

11. The following words, as used in this section, shall have the following meanings unless the context otherwise requires:

a. "Governing body" means the group or the individual ultimately responsible for a hospital's general policies with respect to staff membership and professional privileges and shall include, but not limited to, a board of trustees, a board of directors, a board of governors, a board of managers, a medical board, a director or any other official of a hospital with comparable responsibilities.

b. "Hospital" means an institution for the care and treatment of the sick and injured, equipped with the technical facilities, medical, nursing and other professional and technical personnel necessary for diagnosis and treatment of persons suffering from sickness or injury which requires bed care.

c. "Medical group practice" means the practice of medicine by physicians as partners or in groups with fees and moneys received for professional services furnished by any individual physician, member or employee of such partnership or group pooled and redistributed in accordance with a partnership or other agreement.

d. "Non-profit health insurance" means insurance issued by a non-profit medical expense indemnity corporation in accordance with article forty-three of the insurance law.

e. "Health maintenance organization" means such organization as defined in article forty-four of this chapter.

f. "Comprehensive health services plan" means such plan as defined in article forty-four of this chapter.

§ 206-b. Special requirements with respect to Lyme disease diagnosis.

1. Within thirty days after the effective date of this section, the commissioner shall, in writing, order every physician practicing in Suffolk, Westchester and Nassau counties to review the medical records of any patient such physician treated during the period commencing January first, nineteen hundred seventy-five and ending on the date of such order wherein such physician made a diagnosis of juvenile rheumatoid arthritis and to review the circumstances of such diagnosis to reconsider whether such patient has suffered, or is suffering, from the complex, multi-system disorder caused by the bacterium *Borrelia burgdorferi*, which disease is transmitted by the *Ixodes dammini* tick and is commonly referred to as "Lyme disease". In any case where a hospital or other health care institution or provider has custody or control of the medical records for a patient so diagnosed, upon request such physician shall be entitled to review such medical records for purposes of complying with such order or the commissioner may order any such hospital or other health care institution or provider wherever situated within the state to review such records to reconsider a diagnosis of Lyme disease.

2. The commissioner, upon a showing that there is a reasonable basis to believe that the order provided for herein has not been complied with, shall be entitled to apply to a justice of the supreme court for an order requiring any such physician to submit for the commissioner's consideration such records, charts or other pertinent data which will enable him to determine whether there has been full compliance with such order.

3. In any case where a review of such records indicates that a patient may have been, or is, suffering from Lyme disease, such physician shall, consistent with customary and acceptable medical standards, take such action he deems necessary to inform such patient or in the case of a minor, his or her parent or guardian of his findings, conduct additional tests, administer other necessary treatments or refer such patient to another physician for further diagnosis and/or treatment.

§ 207. Health care and wellness education and outreach program. 1.

There is hereby created within the department the health care and wellness education and outreach program. The department may conduct education and outreach programs for consumers, patients, educators, including but not limited to elementary and secondary school educators, and health care providers relating to any health care matters the commissioner deems appropriate and:

(a) Various health conditions, diseases and health care procedures and treatment options, including but not limited to those for breast, cervical, colorectal, prostate, testicular, skin, and ovarian cancer, shaken baby syndrome, reflex sympathetic dystrophy syndrome and post-polio sequelae.

(b) Recommended preventative and wellness practices and services, including evidence based age and gender appropriate testing and screening exams and immunization schedules.

(c) Lymphedema and lymphatic disease, an abnormal swelling of the extremities including the causes, symptoms of primary lymphedema, secondary lymphedema and lymphatic disease, prevention, early diagnosis, options for treatment and therapy, long-term chronic care issues, the

value of early detection, possible options for treatment including their benefits and risks, and other relevant information and the recommendation that hospitals treating breast cancer patients implement a lymphedema alert program by placing a bright pink wristband on the patient's affected arm. Links to national lymphedema and lymphatic disease organizations shall be provided as part of the informational summary and electronically through the department's websites.

(d) The need for and importance of organ and tissue donation, including living donation, including information about being registered as an organ and tissue donor and executing documents of gift under article forty-three of this chapter; and information to increase patient understanding about the medical option of transplant and its desirability. The department shall consult with the transplant council on the production of any such information and ensure that such information is culturally and linguistically appropriate for all recipients.

(e) The commissioner shall establish a statewide advance care planning campaign to:

(i) promote public awareness of hospice and palliative care services; and palliative care options for patients with a terminal illness or condition;

(ii) inform the public of the importance of advance care planning and the individual's right to direct and participate in health care decisions affecting the individual;

(iii) educate individuals on the tools available to ensure their health care decisions are honored; and

(iv) the need and importance for consumers and patients to have an advance directive, particularly a health care proxy, and the need and importance for health care providers to play a leadership role in discussing end-of-life care preferences and values with patients and to provide patients with health care proxy forms.

(f) Uterine fibroids, an abnormal growth that occurs in the uterus, including the causes and symptoms of uterine fibroids, the value of early detection, possible options for treatment including their benefits and risks, information on the elevated risk for minority women and other relevant information.

(g) Improving birth outcomes, including the importance of

preconceptional care, early prenatal care, considerations of health risks during pregnancy, considerations of benefits and risks of labor and delivery options including, but not limited to, vaginal and cesarean section delivery, elective or repeat cesarean sections, and appropriate use of drugs during delivery. There shall also be education and outreach concerning spina bifida, a permanently disabling birth defect occurring at the end of the first month of pregnancy which involves the incomplete development of the spinal cord or its coverings, and the importance of encouraging all women in their child-bearing years to increase their folic acid intake in order to reduce the incidence of spina bifida.

* (h)(i) Down syndrome including up-to-date and evidence-based information about Down syndrome, not limited to the following:

(1) expected physical, developmental, educational, and psychosocial outcomes;

(2) life expectancy;

(3) the clinical course description;

(4) expected intellectual and functional development;

(5) available intervention or treatment options;

(6) information hotlines specific to Down syndrome;

(7) relevant resource centers or clearinghouses;

(8) national and local Down syndrome organizations; and

(9) any other information the department deems necessary.

Such information shall be provided electronically through the department's website.

(ii) The commissioner shall (1) examine and utilize existing practices to ensure that the information provided under subparagraph (i) of this paragraph is culturally and linguistically appropriate for all recipients; and (2) meet with representatives from the Down syndrome community as necessary to ensure such information is current.

* NB There are 3 par (h)'s

* (h) Drug-induced movement disorders, including the importance of screening for and identifying symptoms of drug-induced movement disorders, treatment for drug-induced movement disorders, and information on methods by which the stigma experienced by people living with drug-induced movement disorders related to the treatment of mental health conditions may be reduced or eliminated. Any such educational

materials disseminated to healthcare providers shall be developed in consultation with the commissioner of the office of mental health, disseminated by the department in coordination with relevant healthcare provider groups, and shall include best practices for the treatment and screening of movement disorders informed by the American Psychiatric Association and other professional society practice guidelines.

* NB There are 3 par (h)'s

* (h) Births of infants with congenital heart defects, including treatment recommendations, and any other information the commissioner deems appropriate.

* NB There are 3 par (h)'s

(i) About the short term and long term adverse health risks to adults and children who become overweight, obese or underweight. The information shall include, but need not be limited to providing citations to the department's website, as well as any other websites providing information on the subject.

* (j) Maternal depression, including information about education, screening, referral services, and possible options for treatment.

* NB There are 2 par (j)'s

* (j) The eating disorders awareness and prevention program shall be designed to promote the awareness of eating disorders and available services, as well as to prevent and reduce the incidence and prevalence of eating disorders, especially among children and adolescents.

* NB There are 2 par (j)'s

* (k) Donating umbilical cord blood to a public cord blood bank.

* NB There are 3 par (k)'s

* (k) The availability of individual, family and group counseling programs, education programs, and advocacy services provided at no cost by governmental agencies and not-for-profit organizations for victims of any sexual offense which constitutes a crime and for victims of child pornography promotion or possession.

* NB There are 3 par (k)'s

* (k) The physical, sexual and psychological consequences of undergoing female genital mutilation, including the practice of "vacation cutting" whereby girls are sent out of state or the country to undergo female genital mutilation, typically during school vacations.

* NB There are 3 par (k)'s

(l) The dangers of women's cancers, including ways to prevent and severity of such diseases. For purposes of this paragraph, women's cancers shall mean and include: cervical, endometrial, gestational trophoblastic tumor, ovarian, uterine sarcoma, vaginal, and vulvar.

* (m) A Lyme disease and tick-borne infection awareness and prevention program designed to promote the awareness and prevention methods against Lyme disease and tick-borne infections. Such information shall include but not be limited to guidelines and methods of prevention, including the safe use of recommended insect repellents, the best practices for tick removal, recommendations for the reduction of exposure to ticks and appropriate course of action once a tick is removed from the body.

* NB There are 3 par (m)'s

* (m) The department shall conduct such a program relating to breast density, which shall include, but not be limited to, educational information regarding the meaning and potential health consequences of having dense breast tissue, the impact of dense breast tissue on mammographic screening for breast cancer and supplemental breast cancer screening techniques, and provide access to other educational websites regarding dense breast tissue and literature regarding risk factors.

* NB There are 3 par (m)'s

* (m) Lupus, a debilitating autoimmune disease that can cause inflammation and tissue damage to virtually any organ system in the body, including the skin, joints, other connective tissue, blood and blood vessels, heart, lung, kidney and brain, and which affects women, particularly women of color, in a disproportionate manner; provided that the program shall include an advisory council under this section that shall include representatives of people with lupus and their families and health care providers who specialize in treating lupus, among others.

* NB There are 3 par (m)'s

(n) Pediatric acute-onset neuropsychiatric syndrome, a clinical diagnosis given to children who have a sudden and dramatic onset of neuropsychiatric symptoms including obsessive compulsive disorder and/or eating disorder, and which may cause affected children to become moody, irritable and anxious, and to have difficulty with schoolwork. Provided that such program shall include an advisory council under this section that shall include representatives of people with pediatric acute-onset

neuropsychiatric syndrome and their families and health care providers who specialize in treating such syndrome, among others.

(o) For women who may become pregnant, expectant parents and parents of infants, information regarding:

(i) the incidence of cytomegalovirus;

(ii) the transmission and risks of cytomegalovirus to pregnant women and women who may become pregnant;

(iii) birth defects caused by congenital cytomegalovirus;

(iv) methods of diagnosing congenital cytomegalovirus;

(v) the available preventive measures to avoid the infection of women who are pregnant or may become pregnant; and

(vi) available methods of treating cytomegalovirus and resources available for families of children born with cytomegalovirus.

* (p) Reproductive health conditions that affect female fertility, including but not limited to polycystic ovary syndrome, endometriosis, and pelvic inflammatory disease.

* NB There are 3 par (p)'s

* (p) Postnatal donation of tissue and fluids.

* NB There are 3 par (p)'s

* (p) Preeclampsia, including information about detection, risk factors and management, and possible options for treatment.

* NB There are 3 par (p)'s

(q) Myalgic encephalomyelitis/chronic fatigue syndrome ("ME/CFS"), a multi-system disease associated with neurological, immunological and energy metabolism impairment characterized by long-standing and debilitating fatigue.

* (r) For those who are experiencing pregnancy loss or infant loss, which shall for the purposes of this paragraph include but not be limited to, miscarriage, stillbirth, or termination for medical reasons, information regarding:

(i) the potential mental and physical impact from such loss; and

(ii) resources for support and follow-up care.

* NB There are 4 par (r)'s

* (r) The physical, sexual, and psychological impact of medical procedures performed on intersex individuals, including those who have not themselves consented to the procedure; provided that the department shall consult with appropriate stakeholders, including, but not limited

to intersex persons, intersex-led organizations, and their chosen advocates, while developing this outreach program.

- * NB There are 4 par (r)'s

- * (r) Sickle cell disease including but not limited to screening, prevention, and treatment information. The department, through the health equity council pursuant to section two hundred forty-three of this article, or a successor council, shall consult with patients with sickle cell disease and their families and health care providers specializing in treating sickle cell disease, among others, in the production of any such information.

- * NB There are 4 par (r)'s

- * (r) Alzheimer's disease and other related dementias; including identification of dementia in health care facilities including but not limited to hospitals, nursing homes, clinics and assisted living facilities; community support services, including caregiver support groups and services, respite, and care management; and resources and information concerning Alzheimer's disease and any other dementia related matters that the commissioner deems appropriate.

- * NB There are 4 par (r)'s

- * (s) Promoting public awareness of the dangers of fatal and non-fatal drowning, including but not limited to the unique risk factors and exposures associated with infant and early drowning, childhood and teenage drowning and adult drowning, the disparate risk of drowning in disadvantaged communities identified pursuant to section 75-0111 of the environmental conservation law and with individuals with a mental disability as defined by subdivision three of section 1.03 of the mental hygiene law, and methods to reduce the risks of drowning, including but not limited to water safety instruction, swim lessons, and awareness of water based risks.

- * NB There are 2 par (s)'s

- * NB Effective June 1, 2025

- * (s) The importance of good oral health, including but not limited to, the impact of oral disease, causes of oral disease and its prevention, oral health across the lifespan, the total body connection, the value of early detection and the availability of oral health services in the community.

- * NB There are 2 par (s)'s

2. Programs under this section, dealing with one or more subjects, may include but not be limited to any of the following elements:

- (a) educational and informational materials in print, audio, visual, electronic or other media;
- (b) public service announcements and advertisements; and
- (c) establishment of toll-free telephone hotlines and electronic services to provide information.

3. The department may produce, make available to others for reproduction, or contract with others to develop such materials mentioned in this section as the commissioner deems appropriate. These materials shall be made available to the public and to educators, including but not limited to elementary and secondary school educators free of charge as appropriate or for a fee under certain circumstances. The commissioner may require where appropriate any health care provider to make these materials available to patients.

4. In exercising any of his or her powers under this section, the commissioner may consult with appropriate health care professionals, providers, consumers, educators and patients or organizations representing them.

5. The commissioner shall ensure that all information and materials produced pursuant to this section are maintained and updated to reflect best practice recommendations.

6. The commissioner may appoint as appropriate advisory councils relating to various matters that are or are proposed to be the subjects of programs under this section. All such councils shall include representation of health care professionals, providers, educators, consumers, patients and other appropriate interests. The members of the councils shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in performance of their duties.

7. In addition to state funds appropriated for programs under this

section, the commissioner may accept grants from public or private sources for these programs. The commissioner, in administering this section, shall seek to coordinate the department's programs with other public and private programs, and may undertake joint or cooperative programs with other public or private entities, including making grants (within amounts appropriated therefor and consistent with applicable law) to public or not-for-profit entities.

8. The commissioner may make rules and regulations necessary and appropriate for implementation of this section.

§ 207-a. Tick-borne diseases and blood-borne pathogen impact study. 1. The department, in conjunction with the commissioner of mental health, shall issue a report examining the mental health impacts of tick-borne diseases and blood-borne pathogens on mental illness rates in endemic areas of the state. Such report shall include but not be limited to:

(a) Considerations of how Lyme, tick-borne illnesses, and other blood-borne pathogens or vector-borne diseases may have correlations with mental illness in infected individuals;

(b) Populations at-risk including those individuals with occupations outdoors and/or increased exposure to vectors;

(c) Diagnostic indicators of mental illness that can be used as guidance for healthcare providers and mental health practitioners;

(d) Historical considerations of infection rates and mental illness indicators that may have gone undiagnosed or misdiagnosed in endemic areas; and

(e) Recommendations for intervention and coordinated care for individuals who exhibit mental illness symptoms as well as those who have both physical and mental health indicators.

2. Such report shall be submitted to the temporary president of the senate and the speaker of the assembly no later than October first, two thousand twenty-two. The department and the commissioner of mental health may engage stakeholders in the compilation of the report, including but not limited to, medical research institutions, health care practitioners, mental health providers, county and local government, and

advocates.

§ 208. Deputy commissioners; appointment; qualifications and duties.

1. The commissioner shall appoint and at pleasure remove a first deputy commissioner and such other deputy commissioners as he shall deem necessary for the proper organization and general classification of the work of the department.

2. The first deputy commissioner shall be a physician licensed or eligible for license to practice medicine and surgery in this state, and who shall have been actively engaged in the practice of his profession for a period of at least five years.

3. The deputy commissioners shall perform such duties as shall be prescribed by the commissioner.

§ 209. Deputy commissioners; compensation. The commissioner shall fix the compensation of deputy commissioners within the amount appropriated therefor by the legislature.

§ 210. Officers and employees; appointment. The commissioner shall appoint such assistant commissioners, officers and other assistants as are necessary for the proper performance of the powers and duties of the department.

§ 211. Training. The commissioner may, within the appropriation allowed therefor, provide suitable training for personnel engaged in or to be engaged in the maintenance or improvement of public health in the state.

§ 211-a. Continuation of salaries of employees of the department while receiving training. The commissioner may, within the amounts

appropriated therefor, continue the salaries, in full or in part, of employees of the department and the institutions in the department while such employees are absent from their regular duties and are receiving training for the better performance of duties, provided that no such compensation shall be so continued to a greater extent than will reimburse such employees for the loss of earnings while receiving such training.

TITLE II

THE PUBLIC HEALTH COUNCIL

- Section 220. Public health and health planning council; appointment of members.
221. Public health and health planning council; terms of office; vacancies.
222. Public health and health planning council; meetings; by-laws.
223. Public health and health planning council; compensation and expenses.
224. Public health and health planning council; secretary, employees.
- 224-b. Public health and health planning council; powers and duties; health care facilities, home care agencies and hospices.
225. Public health and health planning council; powers and duties; sanitary code.
226. Sanitary code; filing and publication.
227. Sanitary code; certified copy; evidence.
228. Sanitary code; application.
229. Sanitary code; violation; penalties.

§ 220. Public health and health planning council; appointment of members. There shall continue to be in the department a public health and health planning council to consist of the commissioner and twenty-six members to be appointed by the governor with the advice and consent of the senate. Membership on the council shall be reflective of

the diversity of the state's population including, but not limited to, the various geographic areas and population densities throughout the state. The members shall include representatives of the public health system, health care providers that comprise the state's health care delivery system, individuals with expertise in the clinical and administrative aspects of health care delivery, issues affecting health care consumers, health planning, health care financing and reimbursement, health care regulation and compliance, and public health practice and at least two members shall also be members of the behavioral health services advisory council; at least four members shall be representatives of general hospitals or nursing homes; at least two members shall be representatives of health care consumer advocacy organizations which have a statewide or regional constituency and have been involved in activities related to health care consumer advocacy including issues of interest to low- and moderate-income individuals; and at least one member shall be a representative of each of the following groups: women's health service providers, home care agencies, freestanding ambulatory surgery centers, diagnostic and treatment centers, health care payors, and labor organizations for health care employees.

§ 221. Public health and health planning council; terms of office; vacancies. 1. The terms of office of members of the public health and health planning council shall be six years. The members of the council shall continue in office until the expiration of their terms and until their successors are appointed and have qualified. Such appointments shall be made by the governor, with the advice and consent of the senate, within one year following the expiration of such terms.

2. Vacancies shall be filled by appointment by the governor for the unexpired terms within one year of the date upon which such vacancies occur.

3. In making appointments to the council, the governor shall seek to ensure that membership on the council reflects the diversity of the state's population including, but not limited to the various geographic

areas and population densities throughout the state.

4. Notwithstanding subdivision one of this section, of the ten members appointed or reappointed to the council on or after December first, two thousand ten, two shall serve a term of three years, two shall serve a term of four years, three shall serve a term of five years, and three shall serve a term of six years. Thereafter, members appointed or reappointed upon expiration of a term of office shall be appointed for a term of six years and shall continue in office until their successors are appointed.

§ 222. Public health and health planning council; meetings; by-laws.

1. The public health and health planning council shall meet as frequently as its business may require, and at least twice in each year.

2. The governor shall designate one of the members of the public health and health planning council as its chair.

3. The public health and health planning council shall enact and from time to time may amend by-laws in relation to its meetings and the transactions of its business.

4. All meetings of the public health and health planning council shall in every proceeding be deemed to have been duly called and regularly held, and all regulations and proceedings to have been duly authorized unless the contrary be proved.

§ 223. Public health and health planning council; compensation and expenses. The members of the public health and health planning council other than the commissioner of health shall receive no compensation for their services, but shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

§ 224. Public health and health planning council; secretary,

employees. The commissioner upon request of the public health and health planning council, shall designate an officer or employee of the department to act as secretary of the public health and health planning council, and shall assign from time to time such other employees as the public health and health planning council may require.

§ 224-b. Public health and health planning council; powers and duties; health care facilities, home care agencies and hospices. The public health and health planning council shall have such powers and duties as are set forth in this chapter, including the consideration of applications for the establishment and construction of health care facilities, home care agencies and hospices licensed under articles twenty-eight, thirty-six or forty of this chapter. In carrying out its powers and duties, the council shall take into account the impact of its actions and recommendations on the quality, accessibility, efficiency and cost-effectiveness of health care throughout the state. The council shall undertake a comprehensive review of regulations and council procedures governing the establishment and construction of such health care facilities, home care agencies and hospices and shall submit to the commissioner any recommendations for the revisions of such regulations. Such review shall be conducted every five years, and the first set of recommendations shall be submitted to the commissioner on or before December first, two thousand sixteen.

§ 225. Public health and health planning council; powers and duties; sanitary code. 1. The public health and health planning council shall, at the request of the commissioner, consider any matter relating to the preservation and improvement of public health, and may advise the commissioner thereon; and it may, from time to time, submit to the commissioner, any recommendations relating to the preservation and improvement of public health.

2. The public health and health planning council shall appoint one or more advisory committees expert in the major areas of public health concern, including but not limited to health education, health manpower,

economics and delivery of health service, sanitation problems and interprofessional relationships. Members of advisory committees need not be members of the public health and health planning council.

3. The public health and health planning council shall have no executive, administrative or appointive duties except as otherwise provided by law.

4. The public health and health planning council shall have power by the affirmative vote of a majority of its members to establish, and from time to time, amend and repeal sanitary regulations, to be known as the sanitary code of the state of New York, subject to approval by the commissioner.

5. The sanitary code may:

(a) deal with any matters affecting the security of life or health or the preservation and improvement of public health in the state of New York, and with any matters as to which the jurisdiction is conferred upon the public health and health planning council;

(b) prescribe the qualifications of public health personnel of the department, directors of divisions, regional health directors, state district health officers, local health officers; county and city health commissioners, deputy and assistant county or city health commissioners; public health administrators; county health directors and deputy and assistant county health directors; directors of county physically handicapped children's programs; directors of medical care (local assistance programs); public health nurses; public health physical therapists; public health educators; nurse-midwives; medical social workers; public health social workers; radiation safety officers; sanitary and public health engineers, sanitarians, sanitary inspectors; public health veterinarians; operators of public water treatment and purification plants; and the qualifications of persons not paid from public funds and who are appointed and employed after January first, nineteen hundred forty-seven, as operators of water treatment or purification plants owned or operated by water companies, corporations or by a person or group of persons serving the general public residing in a political subdivision or any part thereof;

(c) establish regulations for the promotion of health in any or all Indian reservations;

(e) establish regulations for the maintenance of hospitals for communicable diseases;

(f) prescribe standards of efficiency for such laboratories as are under contract with the commissioner for the examination of specimens received from local health officers or physicians for routine examinations and analyses;

(g) set forth the diseases for which specimens shall be submitted for examination to a laboratory approved by the department.

(h) designate the communicable diseases which are dangerous to the public health;

(i) set forth the nature of the information required to be furnished by every physician in his notice to the department of each case of communicable disease.

(j) establish regulations in respect to contact or communication with or use of infected premises, places or things and prescribe the method or methods for the purification and cleansing of the same before general intercourse with the said premises, places or things, or use thereof is allowed;

(k) establish regulations defining the methods and precautions to be observed in disinfecting, cleansing or renovating premises vacated by persons suffering from a communicable disease;

(l) prescribe the qualifications that shall be possessed by persons in charge of diagnostic clinical laboratories as provided by the workmen's compensation law;

(m) require that application be made for a permit to operate a farm or food processing labor camp as defined in the sanitary code; authorize appropriate officers or agencies to issue such a permit when the applicant is in compliance with the established regulations; prescribe standards for living quarters at farm and food processing labor camps, including provisions for sanitary conditions; light, air, and safety; protection from fire hazards; maintenance; and such other matters as may be appropriate for security of life or health, provided however, that the provisions of the sanitary code established pursuant to the provisions hereof shall apply to all farm and food processing labor camps intended to house migrant workers and which are occupied. In the

preparation of such regulations, the public health and health planning council may request and shall receive technical assistance from the board of standards and appeals of the state department of labor and the state building code commission. Such regulation shall be enforced in the same manner as are other provisions of the sanitary code;

(n) prescribe the qualifications of occupational therapists employed in public general hospitals and tuberculosis hospitals and sanatoria maintained pursuant to the general municipal law;

(o) require that application be made for a permit to operate a temporary residence as defined in the sanitary code, or to hold or promote by advertising or otherwise a mass gathering which is likely to attract five thousand people or more and continue for twenty-four hours or more and authorize appropriate officers or agencies to issue such a permit when the applicant is in compliance with the established regulations and when it appears that such temporary residence can be operated or such gathering held without hazard to health and safety; establish regulations with respect to such gatherings to provide for: the furnishing of adequate undertakings to secure full compliance with the sanitary code and other applicable law, adequate and satisfactory water supply and sewerage facilities, adequate drainage, adequate toilet and lavatory facilities, adequate refuse storage and disposal facilities, adequate sleeping areas and facilities, wholesome food and sanitary food service, adequate medical facilities, insect and noxious weed control, adequate fire protection, and such other matters as may be appropriate for security of life or health. In his review of applications for permits for the holding or promoting of such a gathering the permit-issuing official may require such plans, specifications and reports as he shall deem necessary for a proper review, and in his review of such applications, as well as in carrying out his other duties and functions in connection with such a gathering, the permit-issuing official may request and shall receive from all public officers, departments and agencies of the state and its political subdivisions such cooperation and assistance as may be necessary and proper;

(p) establish regulations in respect to ionizing radiation and nonionizing electromagnetic radiation except in relation to special nuclear materials in quantities sufficient to form a critical mass and

excluding the handling and disposal of radioactive wastes and the release of radioactivity to the environment regulated by the state department of environmental conservation. Such regulations may require the posting of a bond or other security;

(q) authorize appropriate officers or agencies to register radiation installations as defined in the sanitary code, issue licenses for the transfer, receipt, possession and use of radioactive materials, other than special nuclear materials in quantities sufficient to form a critical mass, render such inspection and other radiation protection services as may be necessary in the interest of public health, safety and welfare, charge registration fees not to exceed a rate of fifty dollars per installation per annum and, subject to the approval of the commissioner and, in the case of charges by the department, the director of the budget, charge adequate and reasonable fees for licensing, inspection and other radiation protection services not exceeding the estimated costs of such services, except that, with the approval of the commissioner, one or more services may be rendered without any charge.

(r) establish regulations in respect to emergency medical treatment, equipment and services at public functions likely to attract 5,000 or more people, taking into consideration, differences in type, size and duration of function, composition of audience, and accessibility and adequacy of emergency health facilities in the vicinity.

(s) require that application be made for a permit to manufacture for sale at retail frozen desserts as defined in the sanitary code; authorize appropriate officers or agencies to issue such a permit for a fee of twenty-five dollars per annum.

(t) facilitate epidemiological research into the prevention of environmental diseases, by establishing regulations designating as environmentally related diseases those pathological conditions of the body or mind resulting from contact with toxins, mutagens or teratogens in solid, liquid or gaseous form, or in the form of ionizing radiation or nonionizing electromagnetic radiation, and by requiring the reporting of such diseases or suspected cases of such diseases to the department by physicians, medical facilities and clinical laboratories. Any information provided to the department pursuant to such regulations shall be in the form required by the department, and shall be kept confidential and used by the commissioner pursuant to the provisions of

paragraph (j) of subdivision one of section two hundred six of this chapter, and other applicable laws relating to the confidential treatment of patient and medical data, except that the department may share identifying or other information with a local health department when, and only to the extent that, the department determines this information is necessary to protect public health against the hazards associated with exposure to the material. Data shared with the local health department shall not be further disclosed and shall be otherwise subject to the confidentiality requirements of paragraph (j) of subdivision one of section two hundred six of this chapter and any other applicable laws related to the confidential treatment of patient and medical data.

(u) (i) require bacteriological testing of bottled water sold or distributed for use in this state. Such code shall establish requirements for sampling at regular time intervals and in number proportionate to the frequency of production days and the total volume of bottled water sold or distributed for use in this state.

(ii) require physical, inorganic chemical, organic chemical and radiological testing of bottled water. Such testing requirements shall meet or exceed the required parameters and frequencies for public water supplies. Testing for organic and inorganic chemicals shall occur at least annually. Testing for radiological content shall occur at least annually. Such testing shall be conducted on source water and bottled water product. The department shall designate a quarterly period when such annual tests will be conducted. Samples for such testing shall be taken on each production line and tested in labs approved by the department. Lab reports generated from such testing shall be sent directly to the department.

(iii) establish a procedure by which purveyors of bottled water shall certify, to the department, that their bottled water complies with the organic, inorganic, radiological and other water content standards established pursuant to this section. Such certifications shall be submitted to the department in accordance with the testing schedules indicated in subparagraph (ii) of this paragraph, for source water and bottled water product. The department shall at least on a quarterly basis compare random shelf samples of each product line of bottled water and test them for compliance with the standards established pursuant to

this section. If the findings of the random sampling comparison fail to comply with the standards established for bottled water pursuant to this section, the purveyor shall be subject to the penalties and sanctions of this chapter.

(iv) require purveyors who provide sodium content information on bottled water labels to numerically indicate in a manner consistent with federal law and regulation the sodium content of bottled water on labels affixed to bottled water.

(v) require purveyors to indicate, clearly and conspicuously, the bottling date by day, month and year on labels affixed to bottled water.

(vi) require the department of health to give public notice of, and make available to retailers of bottled water, the annual listing of certified bottled water purveyors that indicates only such certified waters may be lawfully sold. If within the annual notification cycle any purveyor is decertified, the department shall give public notice of such decertification. The department shall maintain and make available an updated list of certified purveyors for retailers.

(v) provide for the issuance of variances and waivers from requirements for providing lifeguards at swimming pools and bathing beaches that are part of temporary residences. The code shall provide that variances and waivers shall not expire upon change in ownership of the facility.

5-a. The sanitary code shall provide for the supervision of surf beaches customarily used for swimming or bathing which are owned or operated by a homeowners association by persons qualified as surf lifeguards according to standards for public surf beaches established in such code. For purposes of this subdivision, "surf beaches owned or operated by homeowner associations" shall include bathing beaches owned and operated by a condominium which is property subject to article nine-B of the real property law; a cooperative, in which the property is owned or leased by a corporation, the stockholders of which are entitled to use the bathing beach solely by reason of their ownership of stock in the corporation and occupy apartments for dwelling purposes, provided an "offering statement" or "prospectus" has been filed with the department of law; or an incorporated or unincorporated property association, by which all members own residential property in a fixed or defined

geographical area with deeded rights to use, with similarly situated owners, a defined bathing beach.

5-b. Places of public assembly on-site cardiac automated external defibrillator.

(a) Notwithstanding the provisions of paragraph (r) of subdivision five of this section, the sanitary code shall provide that each place of public assembly shall provide and maintain on-site automated external defibrillators (AED), as defined in paragraph (a) of subdivision one of section three thousand-b of this chapter, in quantities and types deemed by the commissioner to be adequate to ensure ready and appropriate access for use during emergencies.

(b) Whenever places of public assembly are used for public or private sponsored events or activities the owners, operators and administrators responsible for such place of public assembly shall ensure the presence of at least one staff person or volunteer who is trained, pursuant to paragraph (a) of subdivision three of section three thousand-b of this chapter, in the operation and use of an AED.

(c) For the purposes of this subdivision places of public assembly shall be those with an occupancy capacity of at least one thousand people and shall include: (i) all stadiums, ballparks, gymnasiums, field houses, arenas, civic centers and similar facilities used for the conduct of sporting events; and (ii) concert halls, recital halls, theatres, indoor and outdoor amphitheatres or other auditoriums used for the presentation of musical renditions or concerts. Places of public assembly shall not include halls owned by churches, religious organizations, granges, public associations, or free libraries as defined by section two hundred fifty-three of the education law.

(d) Places of public assembly and staff pursuant to paragraphs (a) and (b) of this subdivision shall be subject to the requirements and limitations of section three thousand-b of this chapter.

(e) Pursuant to sections three thousand-a and three thousand-b of this chapter, any public access defibrillation provider, or any employee or other agent of the provider who, in accordance with the provisions of this section, voluntarily and without expectation of monetary compensation renders emergency medical or first aid treatment using an AED which has been made available pursuant to this section, to a person

who is unconscious, ill or injured, shall be liable only pursuant to section three thousand-a of this chapter.

(f) Nothing in this subdivision shall be construed to prohibit a political subdivision of the state from continuing to implement and enforce any local law or regulation related to the placement of automated external defibrillators in places of public assembly as defined in this subdivision, in effect prior to the effective date of this subdivision. Where a political subdivision has a local law in effect prior to the effective date of this subdivision, the provisions of this subdivision shall have no force and effect until such time as the political subdivision repeals its local law.

5-c. Notwithstanding the provisions of paragraph (r) of subdivision five of this section, the sanitary code shall:

(a) provide that any public or private surf beach or swimming facility which is required by any other provision of law to be supervised by a surf lifeguard qualified according to the standards of such code, shall provide and maintain on-site automated external defibrillator (AED) equipment, as defined in paragraph (a) of subdivision one of section three thousand-b of this chapter. Such swimming facilities and staff shall be subject to the requirements and limitations of section three thousand-b of this chapter.

(b) provide that at least one lifeguard trained pursuant to paragraph (a) of subdivision three of section three thousand-b of this chapter in the operation and use of an AED shall be present during all periods of required supervision.

5-d. The state sanitary code shall:

(a) require that all lifeguards employed at children's overnight, summer day, and travelling summer day camps as defined in section thirteen hundred ninety-two of this chapter, meet the following qualifications:

(i) be at least seventeen years of age, except:

(A) a maximum of fifty percent of the required total number of lifeguards on duty may be at least fifteen years of age provided they are under the supervision of a camp aquatics director as required by part seven of the state sanitary code; and

(B) lifeguards required for wilderness swimming must be at least eighteen years of age; and

(ii) meet lifeguarding, first aid and CPR certification requirements for minimum lifeguard supervision levels as required in parts six and seven of the state sanitary code; and

(b) require all qualified lifeguards while on duty at the waterfront to not be engaged in duties or activities which distract them from the direct supervision of the waterfront.

5-e. Places of public assembly on-site epinephrine devices.

(a) Notwithstanding the provisions of paragraph (r) of subdivision five of this section and section three thousand-c of this chapter, the sanitary code shall provide that each place of public assembly as specified in this section shall be required to maintain and make available on-site epinephrine devices, as defined in paragraph (b) of subdivision one of section three thousand-c of this chapter, in quantities and types deemed by the commissioner to be adequate to ensure ready and appropriate access for use during emergencies.

(b) Whenever places of public assembly are used for public or private sponsored events or activities the owners, operators and administrators responsible for such place of public assembly shall ensure the presence of at least one staff person or volunteer who is trained, pursuant to paragraph (c) of subdivision two of section three thousand-c of this chapter, in the operation and use of an epinephrine device.

(c) For the purposes of this subdivision, "places of public assembly" shall mean those with an occupancy capacity of at least one thousand people and shall include: (i) all stadiums, ballparks, gymnasiums, field houses, arenas, civic centers and similar facilities used for the conduct of sporting events; and (ii) concert halls, recital halls, theatres, indoor and outdoor amphitheatres or other auditoriums used for the presentation of musical renditions or concerts. Places of public assembly shall not include halls owned by churches, religious organizations, granges, public associations, or free libraries as defined by section two hundred fifty-three of the education law.

(d) Places of public assembly and staff pursuant to paragraphs (a) and (b) of this subdivision shall be subject to the requirements and limitations of section three thousand-c of this chapter.

(e) Pursuant to sections three thousand-a and three thousand-c of this chapter, any public access epinephrine device provider, or any employee or other agent of the provider who, in accordance with the provisions of this section, voluntarily and without expectation of monetary compensation renders emergency medical or first aid treatment using an epinephrine device which has been made available pursuant to this section, to a person who is unconscious, ill or injured, shall be liable only pursuant to section three thousand-a of this chapter.

(f) Nothing in this subdivision shall be construed to prohibit a political subdivision of the state from continuing to implement and enforce any local law or regulation related to the placement of epinephrine devices in places of public assembly as defined in this subdivision, in effect prior to the effective date of this subdivision. Where a political subdivision has a local law in effect prior to the effective date of this subdivision, the provisions of this subdivision shall have no force and effect until such time as the political subdivision repeals its local law.

(g) (i) Operation of an epinephrine device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

(ii) Operation of an epinephrine device pursuant to this section shall not constitute the unlawful practice of a profession under title eight of the education law.

6. The public health council shall, no later than January first, nineteen hundred seventy-four, prescribe standards and establish regulations for summer day and children's camps which derive all water from a public water supply system and all sewage therefrom is discharged to a public sewer system. Such standards and regulations shall include provisions with respect to: operators, counsellors, living and sleeping quarters, food service facilities, recreational quarters and facilities, occupancy of living and sleeping quarters, and other facilities, protection from fire hazards, safety of arts and crafts and recreational equipment, boating safety, emergency health services, water supply and sewage facilities, refuse storage and disposal facilities, and such other matters as may be appropriate for protection and security of life or health. For purposes of this subdivision, the terms, a "summer day

camp" and a "children's camp" shall have the same definition as appears for those terms in the sanitary code.

7. The public health council shall, no later than January first, nineteen hundred seventy-four, prescribe standards and establish regulations for motels and hotels, as those terms are defined in the sanitary code and which derive all water from a public water supply system and all sewage therefrom is discharged to a public sewer system. Such standards and regulations shall include provisions with respect to: living and sleeping quarters, food service facilities, occupancy of living and sleeping quarters, and other facilities, protection from fire hazards, water supply and sewage facilities, refuse storage and disposal facilities, and such other matters as may be appropriate for protection and security of life or health, provided, however, that the provisions of this section shall not apply in cities having a population of one hundred twenty-five thousand or more.

8. The sanitary code shall delineate specific procedures for public notification of public health hazards to be used by public water suppliers. Such procedures shall include notification of the municipality wherein the public water system is located and the police department serving such municipality.

9. Notwithstanding the provisions of any general, special or local law to the contrary, in cities having a population of one million or more, the sanitary code shall provide that any installation, service, maintenance, testing, repair or modification of a backflow prevention device or any related work shall be performed in conformance with the plumbing code of any such city. All employees of a licensed plumber who perform testing of backflow prevention devices shall satisfactorily complete an approved course in backflow prevention device testing. Nothing in this subdivision shall require the commissioner to certify the completion of such approved course by such employees. For the purposes of this subdivision, "backflow prevention device" means an acceptable air gap, reduced pressure zone device, double check valve assembly or equivalent protective device acceptable to the commissioner that is designed to prevent or contain potential contamination of a

public water system by means of cross-connection control.

10. Notwithstanding the provisions of any general, special or local law to the contrary, the sanitary code of the state of New York shall provide that in any county, city having a population of less than one million, town or village having a plumbing code, the installation, service, maintenance, testing, repair or modification of a backflow prevention device or any related work shall be performed in accordance with such plumbing code. A person licensed under such plumbing code and any of his employees who perform testing of backflow prevention devices shall satisfactorily complete a course in backflow prevention device testing that has been approved by the department. Nothing in this subdivision shall require the commissioner to certify the completion of such approved course by such licensee or employees. For the purposes of this subdivision, "backflow prevention device" means an acceptable air gap, reduced pressure zone device, double check valve assembly or equivalent protective device acceptable to the commissioner that is designed to prevent or contain potential contamination of a public water system by means of cross-connection control.

11. The public health council, in consultation with the superintendent of financial services, shall, no later than March thirty-first, nineteen hundred ninety-three, report to the governor and the legislature regarding the efficacy of developing wellness incentives that could be used to allow premium reductions for certain individuals from established community rates in the individual and small group health insurance markets. Wellness incentives to be considered shall include, but not be limited to, smoking status, physical fitness activities, frequency of physician fitness evaluations and dietary habits. The council shall consider the effects of such wellness incentives on the individual and small group health insurance markets and on the health status of the population as a whole.

12. Notwithstanding the provisions of any general, special or local law to the contrary, a charitable or not-for-profit organization shall not be in violation of this chapter or any rule or regulation thereunder, including the sanitary code, for the possession,

preparation, distribution or service of game or wild game, donated pursuant to section 11-0917 of the environmental conservation law. Game or wild game means any deer or big game, or portions thereof, as defined in section 11-0103 of the environmental conservation law, taken by lawful hunting.

§ 226. Sanitary code; filing and publication. 1. Every regulation adopted by the public health and health planning council shall state the date on which it takes effect, and a copy thereof, duly signed by the secretary of the public health and health planning council, shall be filed as a public record in the department and in the office of the secretary of state.

2. A copy of every regulation adopted by the public health and health planning council shall be sent by the commissioner to each health officer within the state, and shall be published in such manner as the public health and health planning council may from time to time determine.

§ 227. Sanitary code; certified copy; evidence. The sanitary code may be read in evidence from the official compilation of codes, rules and regulations of the state of New York, or supplement thereto. To entitle any copy of the sanitary code, other than the official compilation or supplement thereto, to be read in evidence there shall be contained in the same book or pamphlet a printed certificate of the secretary of state that such copy is a correct transcript of the text of the sanitary code as published in the official compilation or supplement thereto. For such a certificate the secretary of state shall collect such a fee as he shall deem just and reasonable.

§ 228. Sanitary code; application. 1. The provisions of the sanitary code, unless otherwise stated by the public health and health planning council, shall apply to and be effective in all portions of the state and shall supersede all local ordinances heretofore or hereafter enacted

inconsistent therewith.

2. Each county, city, town or village, in the manner hereinafter prescribed, may enact sanitary regulations not inconsistent with the sanitary code established by the public health and health planning council.

3. Local laws, ordinances or regulations which comply with at least the minimum applicable standards set forth in the sanitary code shall be deemed not inconsistent with such code.

§ 229. Sanitary code; violation; penalties. The provisions of the sanitary code shall have the force and effect of law and the non-compliance or non-conformance with any provision thereof shall constitute a violation punishable on conviction for a first offense by a fine not exceeding two hundred fifty dollars or by imprisonment for not exceeding fifteen days, or both; and for a second or subsequent offense by a fine not exceeding five hundred dollars or by imprisonment for not exceeding fifteen days, or both.

TITLE II-A

PROFESSIONAL MEDICAL CONDUCT

Section 230. State board for professional medical conduct; proceedings.

230-a. Penalties for professional misconduct.

230-a*2. Infection control standards.

230-b. Disciplinary proceedings for physician's assistants and specialist's assistants.

230-c. Administrative review board for professional medical conduct.

230-d. Office-based surgery.

230-e. Unauthorized pelvic examinations.

§ 230. State board for professional medical conduct; proceedings. 1. A

state board for professional medical conduct is hereby created in the department in matters of professional misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law. Its physician members shall be appointed by the commissioner at least eighty-five percent of whom shall be from among nominations submitted by the medical society of the state of New York, the New York state osteopathic society, the New York academy of medicine, county medical societies, statewide specialty societies recognized by the council of medical specialty societies, and the hospital association of New York state. Its lay members shall be appointed by the commissioner with the approval of the governor. The board of regents shall also appoint twenty percent of the members of the board. Not less than sixty-seven percent of the members appointed by the board of regents shall be physicians. Not less than eighty-five percent of the physician members appointed by the board of regents shall be from among nominations submitted by the medical society of the state of New York, the New York state osteopathic society, the New York academy of medicine, county medical societies, statewide medical societies recognized by the council of medical specialty societies, and the hospital association of New York state. Any failure to meet the percentage thresholds stated in this subdivision shall not be grounds for invalidating any action by or on authority of the board for professional medical conduct or a committee or a member thereof. The board for professional medical conduct shall consist of not fewer than eighteen physicians licensed in the state for at least five years, two of whom shall be doctors of osteopathy, not fewer than two of whom shall be physicians who dedicate a significant portion of their practice to the use of non-conventional medical treatments who may be nominated by New York state medical associations dedicated to the advancement of such treatments, at least one of whom shall have expertise in palliative care, and not fewer than seven lay members. An executive secretary shall be appointed by the chairperson and shall be a licensed physician. Such executive secretary shall not be a member of the board, shall hold office at the pleasure of, and shall have the powers and duties assigned and the annual salary fixed by, the chairperson. The chairperson shall also assign such secretaries or other persons to the board as are necessary.

2. Members of such board shall be appointed by the commissioner or the board of regents for three year terms except that the terms of those first appointed shall be arranged so that as nearly as possible an equal number shall terminate annually. A vacancy occurring during a term shall be filled by an appointment by the commissioner or the board of regents for the unexpired term.

3. Each member of the board shall receive a certificate of appointment, shall before beginning his term of office file a constitutional oath of office with the secretary of state, shall receive up to one hundred fifty dollars as prescribed by the commissioner for each day devoted to board work not to exceed ten thousand dollars in any one year, and shall be reimbursed for his necessary expenses. Any member may be removed from the board at the pleasure of the commissioner.

4. The governor shall annually designate from the members of the board a chairperson who shall be a physician and vice-chairperson. The board shall meet upon call of the chairperson, and may adopt bylaws consistent with this section. A quorum for the transaction of business by the board shall be a majority of members.

5. From among the members of the board two or more committees on professional conduct shall be appointed by the board chairperson.

6. Any committee on professional conduct appointed pursuant to the provisions of this section shall consist of two physicians and one lay member.

7. (a) The board, by its committees on professional conduct, shall conduct disciplinary proceedings as prescribed in this section and shall assist in other professional conduct matters as prescribed by the chairperson. In this section the term "licensee" shall mean physician, including a physician practicing under a limited permit, a medical resident, physician's assistant and specialist's assistant. A committee on professional conduct, on notice to the licensee and after affording the licensee, the office of professional medical conduct, and their

attorneys an opportunity to be heard, shall have the authority to direct a licensee to submit to a medical or psychiatric examination when the committee has reason to believe the licensee may be impaired by alcohol, drugs, physical disability or mental disability. The committee, with the advice of the licensee and the office of professional medical conduct, shall designate the physician who will conduct the examination. The results of the examination shall be provided by the examining physician to the committee, the licensee, and the office of professional medical conduct. The licensee may also obtain a physician to conduct an examination the results of which shall be provided to the committee and the office of professional medical conduct.

(b) A committee on professional conduct may sit as an administrative tribunal for the purpose of issuing an order authorizing the office of professional medical conduct to obtain medical records or other protected health information pertaining to the licensee's physical or mental condition when the committee has reason to believe that the licensee may be impaired by alcohol, drugs, physical disability or mental disability and that the records or information may be relevant to the alleged impairment or that information regarding the licensee's medical condition may be relevant to an inquiry into a report of a communicable disease, as defined by the state sanitary code or HIV/AIDS. No such order shall be issued except on notice to the licensee and after affording the licensee and the office of professional medical conduct an opportunity to be heard.

(c) A committee on professional conduct, on notice to the licensee and after affording the licensee and the office of professional medical conduct an opportunity to be heard, shall have the authority to direct a licensee to submit to a clinical competency examination when the committee has reason to believe that the licensee has practiced with incompetence, generally in his or her medical practice or in a specific area of his or her medical practice. The committee, with the advice of the licensee and the office of professional medical conduct, shall designate the facility or institution to conduct the clinical competency examination. The results of the clinical competency examination shall be provided by the facility or institution to the committee, the licensee and the office of professional medical conduct. The licensee may also obtain an accredited facility or institution to conduct a clinical

competency examination, the results of which shall be provided to the committee and the office of professional medical conduct.

8. Notwithstanding any other provision of law, no member of a committee on professional conduct nor an employee of the board shall be liable in damages to any person for any action taken or recommendation made by him within the scope of his function as a member of such committee or employee provided that (a) such member or employee has taken action or made recommendations within the scope of his function and without malice, and (b) in the reasonable belief after reasonable investigation that the act or recommendation was warranted, based upon the facts disclosed.

9. Notwithstanding any other provisions of law, neither the proceedings nor the records of any such committee shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.

9-a. At any time, if the board for professional medical conduct or the office of professional medical conduct determines that there is a reasonable belief that an act or omission that constitutes a crime under the law of the state of New York, any other state, or the United States has been committed by the licensee, the board for professional medical conduct or office of professional medical conduct shall notify the appropriate law enforcement official or authority except when the act or omission constitutes legally protected health activity, as defined by section 570.17 of the criminal procedure law.

9-b. Neither the board for professional medical conduct nor the office of professional medical conduct shall charge a licensee with misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law, or cause a report made to the director

of such office to be investigated beyond a preliminary review as set forth in clause (A) of subparagraph (i) of paragraph (a) of subdivision ten of this section, where such report is determined to be based solely upon the recommendation or provision of a treatment modality to a particular patient by such licensee that is not universally accepted by the medical profession, including but not limited to, varying modalities used in the treatment of Lyme disease and other tick-borne diseases. When a licensee, acting in accordance with paragraph e of subdivision four of section sixty-five hundred twenty-seven of the education law, recommends or provides a treatment modality that effectively treats human disease, pain, injury, deformity or physical condition for which the licensee is treating a patient, the recommendation or provision of that modality to a particular patient shall not, by itself, constitute professional misconduct. The licensee shall otherwise abide by all other applicable professional requirements.

9-c. (a) Neither the board for professional medical conduct nor the office of professional medical conduct shall charge a licensee, acting within their scope of practice, with misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law, or cause a report made to the director of such office to be investigated beyond a preliminary review as set forth in clause (A) of subparagraph (i) of paragraph (a) of subdivision ten of this section, where such report is determined to be based solely upon any legally protected health activity, as defined by section 570.17 of the criminal procedure law.

(b) When a licensee, acting within their scope of practice, and in accordance with paragraph e of subdivision four of section sixty-five hundred twenty-seven of the education law, engages in legally protected health activity, as defined by section 570.17 of the criminal procedure law, such legally protected activity shall not, by itself, constitute professional misconduct. The licensee shall otherwise abide by all other applicable professional requirements.

10. Professional misconduct proceedings shall consist of:

* (a) Investigation. (i) (A) The board for professional medical conduct, by the director of the office of professional medical conduct,

may investigate on its own any suspected professional misconduct, and shall investigate each complaint received regardless of the source. By the conclusion of a preliminary review, including an internal clinical review, the director shall determine if a report is based solely upon the recommendation or provision of a treatment modality by a licensee that is not universally accepted by the medical profession, including but not limited to varying modalities used in the treatment of Lyme disease or other tick-borne diseases. Upon a determination by the director that a report is based solely upon the provision of a treatment modality that is not universally accepted, no further review shall be conducted and no charges shall be brought. Nothing in this section shall preclude the director from making such a determination earlier in, or subsequent to, a preliminary review. (B) The director of the office of professional medical conduct shall cause a preliminary review of every report made to the department pursuant to section twenty-eight hundred three-e as added by chapter eight hundred sixty-six of the laws of nineteen hundred eighty, sections twenty-eight hundred five-l and forty-four hundred five-b of this chapter, and section three hundred fifteen of the insurance law, to determine if such report reasonably appears to reflect physician conduct warranting further investigation pursuant to this subparagraph.

(i-a) The director shall, in addition to the determination required by clause (A) of subparagraph (i) of this paragraph, determine if a report is based solely upon conduct which is otherwise permissible pursuant to section sixty-five hundred thirty-one-b of the education law and subdivision nine-c of this section, and upon a determination by the director that a report is based solely upon such permissible conduct, no further review shall be conducted and no charges shall be brought. Nothing in this section shall preclude the director from making such a determination earlier in, or subsequent to, a preliminary review.

(ii) If the investigation of cases referred to an investigation committee involves issues of clinical practice, medical experts, shall be consulted. Experts may be made available by the state medical society of the state of New York, by county medical societies and specialty societies, and by New York state medical associations dedicated to the advancement of non-conventional medical treatments. Any information obtained by medical experts in consultations, including the names of

licensees or patients, shall be confidential and shall not be disclosed except as otherwise authorized or required by law.

(iii) In the investigation of cases referred to an investigation committee, the licensee being investigated shall have an opportunity to be interviewed by the office of professional medical conduct in order to provide an explanation of the issues under investigation. Providing an opportunity for such an interview shall be a condition precedent to the convening of an investigation committee on professional misconduct of the board for professional medical conduct.

(A) At least twenty days before the interview, except as otherwise set forth herein, the licensee under investigation shall be given written notice of: (1) a description of the conduct that is the subject of the investigation; (2) the issues relating to the conduct that have been identified at the time of the notice; (3) the time frame of the conduct under investigation; (4) the identity of each patient whose contact with or care by the licensee is believed to be relevant to the investigation; and (5) the fact that the licensee may be represented by counsel and may be accompanied by a stenographer to transcribe the proceeding. All costs of transcription shall be paid by the licensee and a copy shall be provided to the department by the licensee within thirty days of the interview. The notice required by this subparagraph may be given less than twenty days before an interview in any case where the office of professional medical conduct anticipates that the commissioner will take summary action under subdivision twelve of this section, provided that the notice is given within a reasonable amount of time prior to the interview and advises of the possible summary action.

(B) Within thirty days following the interview or, in a case where a stenographer was present at the interview, within fifteen days after the office of professional medical conduct receives the transcript of the interview, whichever is later, the licensee shall be provided with a copy of the report of the interviewer. In addition, the licensee shall promptly be given written notice of issues identified subsequent to the interview. The licensee may submit written comments or expert opinion or medical or scientific literature that is directly relevant to the issues that have been identified by the office of professional medical conduct to the office of professional medical conduct at any time.

(C) If the director determines that the matter shall be submitted to

an investigation committee, an investigation committee shall be convened within ninety days of any interview of the licensee. The director shall present the investigation committee with relevant documentation including, but not limited to: (1) a copy of the original complaint; (2) the report of the interviewer and the stenographic record if one was taken; (3) the report of any medical or scientific expert; (4) copies of reports of any patient record reviews; and (5) the licensee's submissions.

(D) If the director determines to close an investigation following an interview without presentation to an investigation committee, the office of professional medical conduct shall notify the licensee in writing.

(iv) If the director of the office of professional medical conduct, after obtaining the concurrence of a majority of an investigation committee, and after consultation with the executive secretary, determines that a hearing is warranted the director shall, within fifteen days thereafter, direct counsel to prepare the charges. If the investigation committee is unanimous in its concurrence that a hearing is warranted, the charges shall be made public under paragraph (d) of this subdivision. If the investigation committee is not unanimous in its concurrence that a hearing is warranted, the members of such committee shall vote on whether the charges should be made public, and if all of the committee members vote in favor of publication, the charges shall be made public under paragraph (d) of this subdivision. If the director determines after consultation with an investigation committee that: (A) evidence exists of a single incident of negligence or incompetence, a pattern of inappropriate prescribing or medical practice, or impairment by drugs, alcohol, physical or mental disability; (B) a recommendation was made by a county medical society or the medical society of the state of New York that warrants further review; or (C) the facts underlying a verdict in a medical malpractice action warrant further review, the director, in addition to the authority set forth in this section, shall be authorized to conduct a comprehensive review of patient records of the licensee and such office records of the licensee as are related to said determination. The licensee shall cooperate with the investigation and willful failure to cooperate in a substantial or material respect may result in an enforcement proceeding pursuant to subparagraph (ii) of paragraph (o) of this subdivision. If there is a question of alcoholism,

alcohol abuse, drug abuse or mental illness, the director may refer the matter to a committee, as referred to in subparagraph (ii) of paragraph (c) of subdivision eleven of this section.

(v) The files of the office of professional medical conduct relating to the investigation of possible instances of professional misconduct shall be confidential and not subject to disclosure at the request of any person, except as provided by law in a pending disciplinary action or proceeding. The provisions of this paragraph shall not prevent the office from sharing information concerning investigations within the department and, pursuant to subpoena, with other duly authorized public agencies responsible for professional regulation or criminal prosecution. Nothing in this subparagraph shall affect the duties of notification set forth in subdivision nine-a of this section or prevent the publication of charges or of the findings, conclusions, determinations, or order of a hearing committee pursuant to paragraphs (d) or (g) of this subdivision. In addition, the commissioner may disclose the information when, in his or her professional judgment, disclosure of such information would avert or minimize a public health threat. Any such disclosure shall not affect the confidentiality of other information in the files of the office of professional medical conduct related to the investigation.

(vi) The office of professional medical conduct, acting under this section, may have access to the criminal history record of any licensee governed by the provisions of this section maintained by the division of criminal justice services pursuant to subdivision six of section eight hundred thirty-seven of the executive law.

(vii) The director of the office of professional medical conduct, in consultation with the patient safety center, shall cause a review on a continuous basis of medical malpractice claim and disposition information reported to the commissioner under section three hundred fifteen of the insurance law, for the purpose of identifying potential misconduct. The office shall commence a misconduct investigation if potential misconduct is identified as a result of such review, which shall be based on criteria such as disposition frequency, disposition type including judgment and settlement, disposition award amount, geographic region, specialty, or other factors as appropriate in identifying potential misconduct.

* NB Effective until July 1, 2028

* (a) Investigation. The board for professional medical conduct, by a committee on professional conduct, may investigate on its own any suspected professional misconduct, and shall investigate each complaint received regardless of the source. The results of the investigation shall be referred to the director of the office of professional medical conduct. If the director of the office of professional medical conduct, after consultation with a professional member of the board for professional medical conduct, determines that a hearing is warranted he shall direct counsel to prepare the charges within fifteen days thereafter. If it is determined by the director that the complaint involves a question of professional expertise then such director may seek, and if so shall obtain, the concurrence of at least two members of a panel of three members of the state board for professional medical conduct.

* NB Effective July 1, 2028

(b) Charges. The charges shall state the substance of the alleged professional misconduct and shall state clearly and concisely the material facts but not the evidence by which the charges are to be proved.

(c) Notice of hearing. The board shall set the time and place of the hearing. The notice of hearing shall state (1) the date, time and place of the hearing, (2) that the licensee shall file a written answer to each of the charges and allegations in the statement of charges no later than ten days prior to the hearing, that any charge and allegation not so answered shall be deemed admitted and that the licensee may wish to seek the advice of counsel prior to filing such answer, (3) that the licensee shall appear personally at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state, (4) that the licensee shall have the right to produce witnesses and evidence in his behalf, to cross-examine witnesses and examine evidence produced against him, and to have subpoenas issued in his behalf to require the production of witnesses and evidence in manner and form as prescribed by the civil practice law and rules or either party may issue such subpoenas in their own behalf, (5) that a stenographic record of the hearing will be made, and (6) such other information as may be considered appropriate by the committee.

(d) Service of charges and of notice of hearing. (i) A copy of the charges and the notice of the hearing shall be served on the licensee personally by the board at least thirty days before the hearing. If personal service cannot be made after due diligence and such fact is certified under oath, a copy of the charges and the notice of hearing shall be served by registered or certified mail to the licensee's last known address by the board at least fifteen days before the hearing.

(ii) The charges shall be made public, consistent with subparagraph (iv) of paragraph (a) of this subdivision, no earlier than five business days after they are served, and the charges shall be accompanied by a statement advising the licensee that such publication will occur; provided, however, that charges may be made public immediately upon issuance of the commissioner's order in the case of summary action taken pursuant to subdivision twelve of this section and no prior notification of such publication need be made to the licensee.

(iii) If a hearing on the charges has not yet been conducted or if a hearing has been conducted but the committee has not yet issued a determination, the publication of charges by the department shall include a statement advising that the charges are only allegations which may be contested by the licensee in an administrative hearing, except that no such statement need be included if the licensee fails or affirmatively declines to contest the charges. In the event any or all such charges are dismissed, such dismissal shall be made public within two business days.

(d-1) Disclosure of exculpatory evidence. After service of the charges upon the licensee, counsel for the office of professional medical conduct shall, as soon as practicable and on a continuing basis, provide the licensee with any information or documentation in the possession of the office of professional medical conduct which tends to prove the licensee's innocence.

(e) Committee hearing. The hearing shall be conducted by a committee on professional conduct. The members of the hearing committee shall be appointed by the chairperson of the board who shall designate the committee chairperson. In addition to said committee members, the commissioner shall designate an administrative officer, admitted to practice as an attorney in the state of New York, who shall have the authority to rule on all motions, including motions to compel disclosure

of information or material claimed to be protected because of privilege or confidentiality, procedures and other legal objections and shall draft the conclusions of the hearing committee pursuant to paragraph (g). The administrative officer shall have the authority to rule on objections to questions posed by either party or the committee members. The administrative officer shall not be entitled to vote.

(f) Conduct of hearing. All hearings must be commenced within sixty days of the service of charges except that an adjournment of the initial hearing date may be granted by the hearing committee upon request by either party upon good cause shown. No adjournment shall exceed thirty days. The evidence in support of the charges shall be presented by an attorney. The licensee shall have the rights required to be stated in the notice of hearing (subparagraph (c) of this subdivision) and in section four hundred one of the state administrative procedure act. The committee shall not be bound by the rules of evidence, but its conclusion shall be based on a preponderance of the evidence. A hearing which has been initiated shall not be discontinued because of the death or incapacity to serve of one member of the hearing committee. In the event of a member's death or incapacity to serve on the committee, a member shall be appointed immediately by the chairperson of the board. The member shall affirm in writing that he or she has read and considered evidence and transcripts of the prior proceedings. The last hearing day must be held within one hundred twenty days of the first hearing day. Either party, for good cause shown, may request that the committee extend the last hearing day beyond one hundred twenty days. An extension requested by the licensee and granted by the committee may not be used as the grounds for a proceeding brought under paragraph (j) of this subdivision.

(g) Results of hearing. The committee shall make (1) findings of fact, (2) conclusions concerning the charges sustained or dismissed, and (3) a determination regarding charges sustained or dismissed, and in the event any of the charges have been sustained, of the penalty to be imposed or appropriate action to be taken and the reasons for the determination. For the committee to make a conclusion sustaining a charge, or determining a penalty or the appropriate action to be taken, two members of the committee must vote for such a conclusion or determination. The committee shall issue an order based on its determination. The

committee's findings, conclusions, determinations and order shall become public upon issuance. However, if the time to request a review of the committee's determination has not yet expired, or if the review has been requested but no determination as a result of the review has been issued, such publication shall include a statement advising that the licensee or the department may request a review of the committee's determination. No such statement is required if (a) the time to request such review has expired without the filing of such request by either of the parties, or (b) the licensee and the department both affirmatively decline to request review of the committee's determination or fail to perfect such review. In the event any or all such charges are dismissed, such dismissal shall be made public within two business days.

(h) Disposition of results. (i) The findings, conclusions, determination and the reasons for the determination of the committee shall be served upon the licensee, the department, and any hospitals, primary practice settings or health care plans required to be identified in publicly disseminated physician data pursuant to paragraph (j), (n), or (q) of subdivision one of section twenty-nine hundred ninety-five-a of this chapter, within sixty days of the last day of hearing. Service shall be either by certified mail upon the licensee at the licensee's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail whichever is earlier or by personal service and such service shall be effective upon receipt. The licensee shall deliver to the board the license which has been revoked, annulled, suspended or surrendered, together with the registration certificate, within five days after receipt of the order. If the license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, the licensee shall submit an affidavit to that effect and shall deliver such license or certificate to the board when located. The director of the office shall promptly transmit a copy of the order to the division of professional licensing services of the state education department and to each hospital at which the licensee has privileges.

(ii) When a license has been: (A) revoked or annulled without stay pursuant to subdivision four or five of section two hundred thirty-a of this title; (B) surrendered by a licensee; (C) suspended without stay for more than one hundred eighty days; or (D) restricted to prohibit the

practice of medicine or to preclude the delivery of patient care, the licensee whose license has been so revoked, surrendered, annulled without stay, suspended without stay for more than one hundred eighty days, or restricted shall, within fifteen days of the effective date of the order:

(1) notify his or her patients, of the cessation or limitation of the licensee's medical practice; the names of other physicians or health care practitioners who have agreed to assume responsibility for the patient's care; that the patient should contact one of those named physicians or health care practitioners, or another physician or health care practitioner of the patient's choice, to determine the health care plans, as defined in sections four thousand nine hundred of the insurance law and forty-nine hundred of this chapter, in which the physician or health care practitioner participates and the policies and procedures of such physician or other health care practitioner; that the patient should notify the licensee of the name of the physician or other health care practitioner to whom the patient's medical records should be transferred; and that the licensee will retain, and remain responsible for the maintenance of the patient's medical records until the patient provides notice that the records shall be transferred directly to the patient, consistent with the provisions of sections seventeen and eighteen of this chapter, or to another practitioner of the patient's choice. The licensee shall also notify each health care plan with which the licensee contracts or is employed, and each hospital where he or she has privileges in writing of the cessation or limitation of the licensee's medical practice. Within forty-five days of the effective date of the order, the licensee shall provide the office of professional medical conduct with proof, in a form acceptable to the director of the office of professional medical conduct, that all patients and hospitals have been notified of the cessation or limitation of the licensee's medical practice.

(2) make arrangements for the transfer and maintenance of the medical records of his or her former patients. Records shall be either transferred to the licensee's former patients consistent with the provisions of sections seventeen and eighteen of this chapter or to another physician or health care practitioner as provided in clause (1) of this subparagraph who shall expressly assume responsibility for their

care and maintenance and for providing access to such records, as provided in subdivisions twenty-two and thirty-two of section sixty-five hundred thirty of the education law, the rules of the board of regents or the regulations of the commissioner of education and sections seventeen and eighteen of this chapter. When records are not transferred to the licensee's former patients or to another physician or health care practitioner, the licensee whose license has been revoked, annulled, surrendered, suspended or restricted shall remain responsible for the care and maintenance of the medical records of his or her former patients and shall be subject to additional proceedings pursuant to subdivisions twenty-two, thirty-two and forty of section sixty-five hundred thirty of the education law in the event that the licensee fails to maintain those medical records or fails to make them available to a former patient.

(3) notify the office of professional medical conduct of the name, address, and telephone number of any physician or other health care practitioner who has agreed to accept responsibility for storing and maintaining these medical records.

(4) in the event that the licensee whose license has been revoked, annulled, surrendered or restricted to prohibit the practice of medicine or to preclude the delivery of patient care holds a federal Drug Enforcement Agency (DEA) certificate, advise the DEA in writing of the licensure action, surrender his or her DEA controlled substance privileges to the DEA, and surrender any unused DEA #222 U.S. Official Order Forms, Schedules 1 and 2 to the DEA.

(5) for licensees whose license has been revoked, annulled, surrendered or restricted to prohibit the practice of medicine or to preclude the delivery of patient care, return any unused New York state official prescription forms to the bureau of narcotics enforcement of the department. The licensee shall cause all other prescription pads bearing the licensee's name to be destroyed. If no other licensee is providing services at the licensee's practice location, all medications shall be properly disposed.

(6) for licensees whose license to practice has been revoked, annulled, surrendered or restricted to prohibit the practice of medicine or to preclude the delivery of patient care, refrain from new advertising and make reasonable efforts to cease current advertising by

which his or her eligibility to practice medicine is represented.

In addition to any other penalty provided for in law, failure to comply with the requirements of this subparagraph shall constitute misconduct that may be prosecuted pursuant to this section and which may subject the licensee to the imposition of additional penalties pursuant to section two hundred thirty-a of this title.

(i) The determinations of a committee on professional conduct of the state board for professional medical conduct may be reviewed by the administrative review board for professional medical conduct.

(j) Time limitations. Failure to comply with a provision of this subdivision requiring that a specified action shall be taken within a specified period of time shall be grounds for a proceeding pursuant to article seventy-eight of the civil practice law and rules for an order staying the hearing or dismissing the charges or any part thereof or any other appropriate relief. Such proceeding shall be returnable before the supreme court of Albany county or New York county. The respondent in such proceeding shall have the initial burden to explain the reasons for the failure to comply with a provision of this subdivision requiring that a specified action to be taken within a specified period of time. The court shall not stay the hearing or dismiss the charges or grant any other relief unless it determines that failure to comply was not caused by the article seventy-eight petitioner and has caused substantial prejudice to the article seventy-eight petitioner.

(k) The executive secretary of the board with the specific approval of a committee on professional conduct of the board shall have the power to issue subpoenas requiring persons to appear before the board and be examined with reference to a matter within the scope of the inquiry or the investigation being conducted by the board and produce books, papers, records or documents pertaining thereto.

(l) The board or its representatives may examine and obtain records of patients in any investigation or proceeding by the board acting within the scope of its authorization. Unless expressly waived by the patient, any information so obtained shall be confidential and shall not be disclosed except to the extent necessary for the proper function of the board and the name of the patient may not be disclosed by the board or its employees at any stage of the proceedings unless the patient has

expressly consented. Any other use or dissemination by any person by any means, unless pursuant to a valid court order or otherwise provided by law, is prohibited.

(m) Expedited procedures. (i) Violations. Violations involving professional misconduct of a minor or technical nature may be resolved by expedited procedures as provided in subparagraph (ii) or (iii) of this paragraph. For purposes of this paragraph violations of a minor or technical nature shall include, but shall not be limited to, isolated instances of violations concerning professional advertising or record keeping, and other isolated violations which do not directly affect or impair the public health, welfare or safety.

(ii) Administrative warning and consultation. If the director of the office of professional medical conduct, after obtaining the concurrence of a majority of a committee on professional conduct, and after consultation with the executive secretary, determines that there is substantial evidence of professional misconduct of a minor or technical nature or of substandard medical practice which does not constitute professional misconduct, the director may issue an administrative warning and/or provide for consultation with a panel of one or more experts, chosen by the director. Panels of one or more experts may include, but shall not be limited to, a peer review committee of a county medical society or a specialty board. Administrative warnings and consultations shall be confidential and shall not constitute an adjudication of guilt or be used as evidence that the licensee is guilty of the alleged misconduct. However, in the event of a further allegation of similar misconduct by the same licensee, the matter may be reopened and further proceedings instituted as provided in this section.

(iii) Violation committee proceeding. If the director determines, after obtaining the concurrence of a majority of a committee on professional conduct, and after consultation with the executive secretary, that there is substantial evidence of a violation and that the violation is of a nature justifying a penalty as specified in this subparagraph the department may prepare and serve charges, either by personal service or by certified mail, return receipt requested. A violation committee proceeding shall be commenced within three years of the alleged professional misconduct. Such charges shall include a statement that the matter shall be referred to a committee on

professional conduct, which shall act as a violations committee for determination. The violations committee shall be appointed by the chairperson of the state board. Paragraph (c) of subdivision ten of this section shall apply to the proceeding. A stenographic record of the hearing shall be made. The evidence in support of the charges shall be presented by an attorney and the licensee shall be afforded an opportunity to be heard and to present evidence in his behalf. Such violations committee may issue a censure and reprimand, may require the licensee to perform up to twenty-five hours of public service in a facility licensed pursuant to article twenty-eight of this chapter in a manner and at a time and place directed by the board, and in addition, or in the alternative, may impose a fine not to exceed five hundred dollars for each specification of minor or technical misconduct. The violations committee may alternatively dismiss the charges in the interest of justice. The order shall be served either by certified mail to the licensee's last known address and such services shall be effective upon receipt or seven days after mailing by certified mail whichever is earlier or by personal service and such service shall be effective upon receipt. The order may be reviewed by the administrative appeals board for professional medical conduct.

(n) Engagement. A proceeding under this section shall be treated in the same manner as an action or proceeding in supreme court for the purpose of any claim by counsel of actual engagement.

(o) Orders for review of medical records. Where the director has issued an order for a comprehensive medical review of patient records and office records pursuant to subparagraph four of paragraph (a) of this subdivision and the licensee has refused to comply with the director's order, the director may apply to a justice of the supreme court, in writing, on notice to the licensee, for a court order to compel compliance with the director's order. The court shall not grant the application unless it finds that (i) there was a reasonable basis for issuance of the director's order and (ii) there is reasonable cause to believe that the records sought are relevant to the director's order. The court may deny the application or grant the application in whole or in part.

(p) Convictions of crimes or administrative violations. In cases of professional misconduct based solely upon a violation of subdivision

nine of section sixty-five hundred thirty of the education law, the director may direct that charges be prepared and served and may refer the matter to a committee on professional conduct for its review and report of findings, conclusions as to guilt, and determination. In such cases, the notice of hearing shall state that the licensee shall file a written answer to each of the charges and allegations in the statement of charges no later than ten days prior to the hearing, and that any charge or allegation not so answered shall be deemed admitted, that the licensee may wish to seek the advice of counsel prior to filing such answer that the licensee may file a brief and affidavits with the committee on professional conduct, that the licensee may appear personally before the committee on professional conduct, may be represented by counsel and may present evidence or sworn testimony in his or her behalf, and the notice may contain such other information as may be considered appropriate by the director. The department may also present evidence or sworn testimony and file a brief at the hearing. A stenographic record of the hearing shall be made. Such evidence or sworn testimony offered to the committee on professional conduct shall be strictly limited to evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee. Where the charges are based on the conviction of state law crimes in other jurisdictions, evidence may be offered to the committee which would show that the conviction would not be a crime in New York state. The committee on professional conduct may reasonably limit the number of witnesses whose testimony will be received and the length of time any witness will be permitted to testify. The determination of the committee shall be served upon the licensee and the department in accordance with the provisions of paragraph (h) of this subdivision. A determination pursuant to this subdivision may be reviewed by the administrative review board for professional medical conduct.

(q) At any time subsequent to the final conclusion of a professional misconduct proceeding against a licensee, whether upon the determination and order of a hearing committee issued pursuant to paragraph (h) of this subdivision or upon the determination and order of the administrative review board issued pursuant to paragraph (d) of subdivision four of section two hundred thirty-c of this title, the licensee may file a petition with the director, requesting vacatur or

modification of the determination and order. The director shall, after reviewing the matter and after consulting with department counsel, determine in the reasonable exercise of his or her discretion whether there is new and material evidence that was not previously available which, had it been available, would likely have led to a different result, or whether circumstances have occurred subsequent to the original determination that warrant a reconsideration of the measure of discipline. Upon determining that such evidence or circumstances exist, the director shall have the authority to join the licensee in an application to the chairperson of the state board for professional medical conduct to vacate or modify the determination and order, as the director may deem appropriate. Upon the joint application of the licensee and the director, the chairperson shall have the authority to grant or deny such application.

11. Reporting of professional misconduct:

(a) The medical society of the state of New York, the New York state osteopathic society or any district osteopathic society, any statewide medical specialty society or organization, and every county medical society, every person licensed pursuant to articles one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-three, one hundred thirty-seven and one hundred thirty-nine of the education law, and the chief executive officer, the chief of the medical staff and the chairperson of each department of every institution which is established pursuant to article twenty-eight of this chapter and a comprehensive health services plan pursuant to article forty-four of this chapter or article forty-three of the insurance law, shall, and any other person may, report to the board any information which such person, medical society, organization institution or plan has which reasonably appears to show that a licensee is guilty of professional misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law. Such reports shall remain confidential and shall not be admitted into evidence in any administrative or judicial proceeding except that the board, its staff, or the members of its committees may begin investigations on the basis of such reports and may use them to develop further information.

(b) Any person, organization, institution, insurance company,

osteopathic or medical society who reports or provides information to the board in good faith, and without malice shall not be subject to an action for civil damages or other relief as the result of such report.

(c) Notwithstanding the foregoing, no physician shall be responsible for reporting pursuant to paragraph (a) of this subdivision with respect to any information discovered by such physician solely as a result of:

(i) Participation in a properly conducted mortality and/or morbidity conference, departmental meeting or a medical or tissue committee constituted pursuant to the by-laws of a hospital which is duly established pursuant to article twenty-eight of the public health law, unless the procedures of such conference, department or committee of such hospital shall have been declared to be unacceptable for the purpose hereof by the commissioner, and provided that the obligations of reporting such information when appropriate to do so shall be the responsibility of the chairperson of such conference, department or committee, or

* (ii) Participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of New York or the New York State Osteopathic Society whose purpose is to confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse, or mental illness. Such demonstration period shall commence on April first, nineteen hundred eighty and terminate on May thirty-first, nineteen hundred eighty-three. An additional demonstration period shall commence on June first, nineteen hundred eighty-three and terminate on March thirty-first, nineteen hundred eighty-six. An additional demonstration period shall commence on April first, nineteen hundred eighty-six and terminate on March thirty-first, nineteen hundred eighty-nine. An additional demonstration period shall commence April first, nineteen hundred eighty-nine and terminate March thirty-first, nineteen hundred ninety-two. An additional demonstration period shall commence April first, nineteen hundred ninety-two and terminate March thirty-first, nineteen hundred ninety-five. An additional demonstration period shall commence on April first, nineteen hundred ninety-five and terminate on March thirty-first, nineteen hundred ninety-eight. An additional demonstration period shall commence on April first, nineteen hundred ninety-eight and terminate on March thirty-first, two thousand three. An

additional demonstration period shall commence on April first, two thousand three and terminate on March thirty-first, two thousand thirteen. An additional demonstration period shall commence April first, two thousand thirteen and terminate on March thirty-first, two thousand eighteen. An additional demonstration period shall commence April first, two thousand eighteen and terminate on July first, two thousand twenty-eight provided, however, that the commissioner may prescribe requirements for the continuation of such demonstration program, including periodic reviews of such programs and submission of any reports and data necessary to permit such reviews. During these additional periods, the provisions of this subparagraph shall also apply to a physician committee of a county medical society.

* NB Expires July 1, 2028

(d) In the event that a physician or administrator of a hospital established pursuant to article twenty-eight of this chapter shall reasonably be unable to determine if any information which he or she has is such that it does reasonably appear to show that a licensee is guilty of professional misconduct and therefore creates an obligation on such physician or such administrator to make a report pursuant to paragraph (a) hereof, he or she may either:

(i) in accordance with procedures established by the board, and without revealing the name of the licensee who he or she is considering making such a report about, request in writing the advice of the board as to whether or not a report should be made, and the physician or administrator so requesting such advice shall then be required to comply with the advice of the board. No such request for advice shall relieve the requesting physician or administrator of any obligation hereunder unless all other material facts are revealed, other than the name of the licensee in question, or

(ii) in the case where the licensee about whom another physician is considering making such report is affiliated with a hospital which is duly established pursuant to article twenty-eight of this chapter, a physician may elect to fulfill the obligations of paragraph (a) hereof by reporting such information to the appropriate executive committee or professional practices peer review committee which is duly constituted pursuant to by-laws of such hospital, unless the peer review procedures of such hospital shall have been declared to be unacceptable for the

purposes hereof by the commissioner. The physician members of such hospital executive committee or professional practices peer review committee shall thereupon have the responsibility of reporting such information to the board pursuant to paragraph (a) hereof, as required thereby, but in the event that such committee determines that a report shall be made to the board, the chairperson of such committee may fulfill the obligation of reporting on behalf of all the members of the committee, or

(iii) in a case where the physician, about whom he or she is considering making such report, is a member of a county medical society or district osteopathic society, and is not affiliated with a hospital, but practices his or her profession within such county or district, a physician may elect to fulfill the obligations of paragraph (a) hereof by reporting such information to the appropriate county medical society's or district osteopathic society's professional practices review committee duly constituted pursuant to the by-laws of such county medical society or district osteopathic society, unless the review procedures of such county medical society or district osteopathic society shall have been declared to be unacceptable for the purposes hereof by the commissioner. The physician members of such review committee shall thereupon have the responsibility of reporting such information to the board pursuant to paragraph (a) hereof, as required thereby, but in the event that such committee determines that a report shall be made to the board, the chairperson of such committee may fulfill the obligation of reporting on behalf of all the members of the committee.

(e) Nothing contained in this subdivision shall be so construed as to require any physician to violate a physician/patient privilege and therefore, no physician shall be required to report any information to the board which such physician has learned solely as a result of rendering treatment to another physician.

(f) A violation of this subdivision shall not be subject to the provisions of sections twelve and twelve-b of this chapter.

* (g) (i) Any physician committee of the Medical Society of the State of New York, the New York State Osteopathic Society or a county medical society referred to in subparagraph (ii) of paragraph (c) of this subdivision shall develop procedures in consultation with, and approved

by, the commissioner, including but not limited to the following:

(A) The committee shall disclose at least once a month such information as the director of the office of professional medical conduct may deem appropriate regarding reports received, contacts or investigations made and the disposition of each report, provided however that the committee shall not disclose any personally identifiable information except as provided in clause (B) or (C) of this subparagraph.

(B) The committee shall immediately report to the director the name, all information obtained and the results of any contact or investigation regarding any physician who is believed to be an imminent danger to the public.

(C) The committee shall report to the director in a timely fashion all information obtained regarding any physician who refuses to cooperate with the committee, refuses to submit to treatment, or whose impairment is not substantially alleviated through treatment.

(D) The committee shall inform each physician who is participating in a program of the procedures followed in the program, of the rights and responsibilities of the physician in the program and of the possible results of noncompliance with the program.

** (ii) No member of any such committee; nor the Medical Society of the State of New York, the New York State Osteopathic Society or a county medical society referred to in subparagraph (ii) of paragraph (c) of this subdivision that establishes a committee; nor any agent, servant, representative or employee that provides service to any such committee or society, shall be liable for damages to any person for any action taken by such committee, society, member, agent, servant, representative or employee provided that such action was taken without malice and within the scope of such individual's or entity's function in relation to such committee.

** NB Repealed July 1, 2028

** (iii) The committee, in conjunction with the director of the office of professional medical conduct, shall develop appropriate consent forms and disclosure proceedings as may be necessary under any federal statute, rule or regulation in order to permit the disclosure of the information as may be required under clauses (B) and (C) of subparagraph (i) of this paragraph.

** NB Repealed July 1, 2028

**(iv) Except as provided in this paragraph and notwithstanding any other provision of law, neither the proceedings nor the records of any such physician committee shall be subject to disclosure under article thirty-one of the civil practice law and rules nor shall any member of any such committee nor any person in attendance at any such meeting be required to testify as to what transpired thereat.

** NB Repealed July 1, 2028

* NB Expires July 1, 2028

(h) The office of professional medical conduct shall post on its website information on patients' rights and reporting options under this subdivision regarding professional misconduct, which shall specifically include information on reporting instances of misconduct involving sexual harassment and assault. All physicians' practice settings shall conspicuously post signage, visible to their patients, directing such patients to the office of professional medical conduct's website for information about their rights and how to report professional misconduct.

12. Summary action. (a) Whenever the commissioner, (i) after being presented with information indicating that a licensee is causing, engaging in or maintaining a condition or activity which has resulted in the transmission or suspected transmission, or is likely to lead to the transmission, of communicable disease as defined in the state sanitary code or HIV/AIDS, by the state and/or a local health department and if in the commissioner's opinion it would be prejudicial to the interests of the people to delay action until an opportunity for a hearing can be provided in accordance with the prehearing and hearing provisions of this section; or (ii) after an investigation and a recommendation by a committee on professional conduct of the state board for professional medical conduct, based upon a determination that a licensee is causing, engaging in or maintaining a condition or activity which in the commissioner's opinion constitutes an imminent danger to the health of the people, and that it therefore appears to be prejudicial to the interests of the people to delay action until an opportunity for a hearing can be provided in accordance with the prehearing and hearing provisions of this section; the commissioner may order the licensee, by

written notice, to discontinue such dangerous condition or activity or take certain action immediately and for a period of ninety days from the date of service of the order. Within ten days from the date of service of the said order, the state board for professional medical conduct shall commence and regularly schedule such hearing proceedings as required by this section, provided, however, that the hearing shall be completed within ninety days of the date of service of the order. To the extent that the issue of imminent danger can be proven without the attorney representing the office of professional medical conduct putting in its entire case, the committee of the board shall first determine whether by a preponderance of the evidence the licensee is causing, engaging in or maintaining a condition or activity which constitutes an imminent danger to the health of the people. The attorney representing the office of professional medical conduct shall have the burden of going forward and proving by a preponderance of the evidence that the licensee's condition, activity or practice constitutes an imminent danger to the health of the people. The licensee shall have an opportunity to be heard and to present proof. When both the office and the licensee have completed their cases with respect to the question of imminent danger, the committee shall promptly make a recommendation to the commissioner on the issue of imminent danger and determine whether the summary order should be left in effect, modified or vacated, and continue the hearing on all the remaining charges, if any, in accordance with paragraph (f) of subdivision ten of this section. Within ten days of the committee's recommendation, the commissioner shall determine whether or not to adopt the committee's recommendations, in whole or in part, and shall leave in effect, modify or vacate his summary order. The state board for professional medical conduct shall make every reasonable effort to avoid any delay in completing and determining such proceedings. If, at the conclusion of the hearing, (i) the hearing committee of the board finds the licensee guilty of one or more of the charges which are the basis for the summary order, (ii) the hearing committee determines that the summary order continue, and (iii) the ninety day term of the order has not expired, the summary order shall remain in full force and effect until a final decision has been rendered by the committee or, if review is sought, by the administrative review board. A summary order shall be public upon issuance.

(b) When a licensee has pleaded or been found guilty or convicted of committing an act constituting a felony under New York state law or federal law, or the law of another jurisdiction which, if committed within this state, would have constituted a felony under New York state law, or when a licensee has been charged with committing an act constituting a felony under New York state or federal law or the law of another jurisdiction, where the licensee's alleged conduct, which, if committed within this state, would have constituted a felony under New York state law, and in the commissioner's opinion the licensee's alleged conduct constitutes an imminent danger to the health of the people, or when the duly authorized professional disciplinary agency of another jurisdiction has made a finding substantially equivalent to a finding that the practice of medicine by the licensee in that jurisdiction constitutes an imminent danger to the health of its people, or when a licensee has been disciplined by a duly authorized professional disciplinary agency of another jurisdiction for acts which if committed in this state would have constituted the basis for summary action by the commissioner pursuant to paragraph (a) of this subdivision, the commissioner, after a recommendation by a committee of professional conduct of the state board for professional medical conduct, may order the licensee, by written notice, to discontinue or refrain from practicing medicine in whole or in part or to take certain actions authorized pursuant to this title immediately. The order of the commissioner shall constitute summary action against the licensee and become public upon issuance. The summary suspension shall remain in effect until the final conclusion of a hearing which shall commence within ninety days of the date of service of the commissioner's order, end within ninety days thereafter and otherwise be held in accordance with paragraph (a) of this subdivision, provided, however, that when the commissioner's order is based upon a finding substantially equivalent to a finding that the practice of medicine by the licensee in another jurisdiction constitutes an imminent danger to the health of its people, the hearing shall commence within thirty days after the disciplinary proceedings in that jurisdiction are finally concluded. If, at any time, the felony charge is dismissed, withdrawn or reduced to a non-felony charge, the commissioner's summary order shall terminate.

13. (a) Temporary surrender. The license and registration of a licensee who may be temporarily incapacitated for the active practice of medicine and whose alleged incapacity has not resulted in harm to a patient may be voluntarily surrendered to the board for professional medical conduct, which may accept and hold such license during the period of such alleged incapacity or the board for professional medical conduct may accept the surrender of such license after agreement to conditions to be met prior to the restoration of the license. The board shall give prompt written notification of such surrender to the division of professional licensing services of the state education department, and to each hospital at which the licensee has privileges. The licensee whose license is so surrendered shall notify all patients and all persons who request medical services that the licensee has temporarily withdrawn from the practice of medicine. The licensure status of each such licensee shall be "inactive" and the licensee shall not be authorized to practice medicine. The temporary surrender shall not be deemed to be an admission of disability or of professional misconduct, and shall not be used as evidence of a violation of subdivision seven or eight of section sixty-five hundred thirty of the education law unless the licensee practices while the license is "inactive". Any such practice shall constitute a violation of subdivision twelve of section sixty-five hundred thirty of the education law. The surrender of a license under this subdivision shall not bar any disciplinary action except action based solely upon the provisions of subdivision seven or eight of section sixty-five hundred thirty of the education law and where no harm to a patient has resulted, and shall not bar any civil or criminal action or proceeding which might be brought without regard to such surrender. A surrendered license shall be restored upon a showing to the satisfaction of a committee of professional conduct of the state board for professional medical conduct that the licensee is not incapacitated for the active practice of medicine provided, however, that the committee may impose reasonable conditions on the licensee, if it determined that due to the nature and extent of the licensee's former incapacity such conditions are necessary to protect the health of the people. The chairperson of the committee shall issue a restoration order adopting the decision of the committee. Prompt written notification of such restoration shall be given to the division of professional

licensing services of the state education department and to all hospitals which were notified of the surrender of the license.

(b) Permanent surrender. The license and registration of a licensee who may be permanently incapacitated for the active practice of medicine, and whose alleged incapacity has not resulted in harm to a patient, may be voluntarily surrendered to the board for professional medical conduct. The board shall give prompt written notification of such surrender to the division of professional licensing services of the state education department, and to each hospital at which the licensee has privileges. The licensee whose license is so surrendered shall notify all patients and all persons who request medical services that the licensee has permanently withdrawn from the practice of medicine. The permanent surrender shall not be deemed to be an admission of disability of or professional misconduct, and shall not be used as evidence of a violation of subdivision seven or eight of section sixty-five hundred thirty of the education law. The surrender shall not bar any civil or criminal action or proceeding which might be brought without regard to such surrender. There shall be no restoration of a license that has been surrendered pursuant to this subdivision.

14. Reports. The board shall prepare an annual report for the legislature, the governor and other executive offices, the medical profession, medical professional societies, consumer agencies and other interested persons. Such report shall include, but shall not be limited to, a description and analysis of the administrative procedures and operations based upon a statistical summary relating to (i) discipline, (ii) complaint, investigation, and hearing backlog and (iii) budget. Information provided for these sections shall be enumerated by regional office of the office of professional medical conduct.

* 15. The commissioner shall make grants to any physician committee as referred to in subparagraph (ii) of paragraph (c) of subdivision eleven of this section to fund the operations of such committee during the authorized demonstration period. Grants shall be awarded pursuant to an expenditure plan developed by the sponsoring organization in consultation with, and approved by the commissioner. No funds shall be made available unless the committee's procedures have been approved by the commissioner pursuant to paragraph (g) of subdivision eleven of this

section.

* NB Repealed July 1, 2028

16. Liability. Notwithstanding any other provision of law, persons who assist the department as consultants, expert witnesses, administrative officers or monitors in the investigation, prosecution or hearing of alleged professional misconduct, licensure matters, restoration proceedings, probation, or criminal prosecutions for unauthorized practice, shall not be liable for damages in any civil action or proceeding as a result of such assistance, except upon proof of actual malice. The attorney general shall defend such persons in any such action or proceeding, in accordance with section seventeen of the public officers law.

17. Monitoring. (a) A licensee may be ordered to have his or her practice monitored by another appropriate licensee after investigation and review pursuant to paragraph (a) of subdivision ten of this section, if there is reason to believe that the licensee is unable to practice medicine with reasonable skill and safety to patients.

(b) The director of the office of professional medical conduct, after consultation with the executive secretary, shall direct counsel to prepare a notice detailing the reasonable cause and a copy of the notice shall be served on the licensee. The matter shall be presented to a committee on professional conduct by an attorney for the department and the licensee shall have the opportunity to be heard by such committee and may be represented by counsel. A stenographic record of the proceeding shall be made. Service of the notice shall be in accordance with the methods of service authorized by paragraph (d) of subdivision ten of this section.

(c) If the committee determines that reasonable cause exists as specified in paragraph (a) of this subdivision and that there is insufficient evidence for the matter to constitute misconduct as defined in sections sixty-five hundred thirty and section sixty-five hundred thirty-one of the education law, the committee may issue an order directing that the licensee's practice of medicine be monitored for a period specified in the order, which shall in no event exceed one year, by a licensee approved by the director, which may include members of

county medical societies or district osteopathic societies designated by the commissioner. The licensee responsible for monitoring the licensee shall submit regular reports to the director. If the licensee refuses to cooperate with the licensee responsible for monitoring or if the monitoring licensee submits a report that the licensee is not practicing medicine with reasonable skill and safety to his or her patients, the committee may refer the matter to the director for further proceedings pursuant to subdivision ten of this section. An order pursuant to this paragraph shall be kept confidential and shall not be subject to discovery or subpoena, unless the licensee refuses to comply with the order.

(d) A licensee may not seek the appointment of a monitor pursuant to this subdivision in lieu of an order issued pursuant to subdivision seven of this section or a disciplinary proceeding pursuant to subdivision ten or twelve of this section.

18. (a) The director shall have the authority to monitor physicians, physician's assistants and specialist's assistants who have been placed on probation pursuant to a determination of professional misconduct by the board. During such period of probation, the director, or his or her designee, as provided in the order of the board, and after consultation with the executive secretary, (i) may review the professional performance of the licensee by randomly selecting office records, patient records and hospital charts, (ii) may require periodic visits by the licensee to a member of the state board for professional medical conduct or an employee of the office of professional medical conduct, (iii) may require the licensee to obtain an appropriate monitor, approved by the director, to monitor the licensee's practice, (iv) may require an audit of the licensee's billings for services rendered during probation, (v) may require the licensee to submit on a random basis to tests for the presence of alcohol or drugs, (vi) may require the licensee to obtain additional training prior to completion of the probation, (vii) may require the licensee to work in a supervised setting, (viii) may require, as a condition of the licensee's continued practice, that the licensee undergo therapy and/or treatment approved and monitored by the director, (ix) may require that the licensee comply with the requirements of the penalty imposed, and (x) may impose upon

the licensee such additional requirements as reasonably relate to the misconduct found or are necessary to protect the health of the people pursuant to regulation. The director is authorized to delegate some or all of the foregoing responsibilities to designated county medical societies and district osteopathic societies.

(b) Any health care provider licensed pursuant to this chapter or the education law, hospital licensed pursuant to article twenty-eight of this chapter or medical school that participates in a monitoring or remediation program pursuant to this subdivision and subdivision seventeen of this section shall not be liable for the negligence of the monitored licensee in providing medical care pursuant to a monitoring program. However, this paragraph does not diminish the participating provider's, hospital's or school's liability for failure to exercise reasonable care in properly carrying out its responsibilities under the program. The monitored licensee shall be required to maintain medical malpractice insurance coverage with limits no less than two million dollars per occurrence and six million dollars per policy year.

19. Upon receipt of information that indicates a licensee may be in violation of the terms or conditions of probation, the director of the office of professional medical conduct shall conduct an investigation. If the director determines that a licensee may have violated probation, the director shall give notice by letter to the licensee of the facts forming the basis of the alleged violation of probation by the licensee, that the licensee has a right to a hearing and may be represented by counsel. If the licensee does not dispute the facts forming the basis of the alleged violation of probation within twenty days of the date of the letter, the director shall submit the matter to a committee on professional conduct for its review and determination. If within twenty days of the date of the letter, the licensee disputes any of the facts forming the basis of the alleged violation of probation, the licensee shall be afforded a hearing before a committee on professional conduct to hear and make findings of fact, conclusions of law and a determination. A stenographic record of the hearing shall be made. The committee, after providing a licensee with an opportunity to be heard, shall determine whether the licensee has violated probation and shall impose an appropriate penalty as defined in section two hundred thirty-a

of this title. In determining the appropriate penalty, the committee shall consider both the violation of probation and the prior adjudication of misconduct. The chairperson of the committee shall issue an order adopting the decision of the committee on professional conduct. The order may be reviewed by the administrative review board for professional medical conduct.

*** § 230-a. Penalties for professional misconduct.** The penalties which may be imposed by the state board for professional medical conduct on a present or former licensee found guilty of professional misconduct under the definitions and proceedings prescribed in section two hundred thirty of this title and sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law are:

1. Censure and reprimand;
2. Suspension of license, (a) wholly, for a fixed period of time; (b) wholly, except to the limited extent required for the licensee to successfully complete a course of retraining; (c) wholly, until the licensee successfully completes a course of therapy or treatment prescribed by the board; (d) wholly, until the licensee completes rehabilitation to the satisfaction of the board; (e) wholly, until the licensee complies with the terms or conditions of a board order; (f) partially, until the licensee successfully completes a course of retraining in the area to which the suspension applies; (g) partially, for a specified period or until the licensee complies with the terms or conditions of a board order;
3. Limitation of the license to a specified area or type of practice;
4. Revocation of license;
5. Annulment of license or registration;
6. Limitation on registration or issuance of any further license;

7. A fine not to exceed ten thousand dollars upon each specification of charges of which the respondent is determined to be guilty;

8. A requirement that a licensee pursue a course of education or training; and

9. A requirement that a licensee perform up to five hundred hours of public service in a manner and at a time and place as directed by the board. The board may stay such penalties in whole or in part or place the licensee on probation with or without imposition of one of the penalties provided pursuant to this section. Any fine imposed pursuant to this section or pursuant to paragraph (m) of subdivision ten of section two hundred thirty of this title may be sued for and recovered in the name of the people of the state of New York in an action brought by the attorney general. In such action, the findings, determinations and order of the board shall be admissible evidence and shall be conclusive proof of the violation and the penalty assessed.

* NB There are 2 § 230-a's

* **§ 230-a. Infection control standards.** Notwithstanding any law to the contrary, including section sixty-five hundred thirty-two of the education law, the department shall promulgate rules or regulations describing scientifically accepted barrier precautions and infection control practices as standards of professional medical conduct for persons licensed under articles one hundred thirty-one and one hundred thirty-one-B of the education law. The department shall consult with the education department to ensure that regulatory standards for scientifically acceptable barrier precautions and infection prevention techniques promulgated pursuant to this section are consistent, as far as appropriate with such standards adopted by the education department applicable to persons licensed under the education law other than articles one hundred thirty-one and one hundred thirty-one-B of such law.

* NB There are 2 § 230-a's

§ 230-b. Disciplinary proceedings for physician's assistants and specialist's assistants. Disciplinary proceedings involving physician's assistants and specialist's assistants shall be conducted in accordance with the provisions of section two hundred thirty of this title.

§ 230-c. Administrative review board for professional medical conduct.

1. There is hereby created an administrative review board for professional medical conduct for the purpose of reviewing determinations of committees on professional conduct of the state board for professional medical conduct. The review board may not review a commissioner's summary order under subdivision twelve of section two hundred thirty of this title.

2. The review board shall consist of five members of the board appointed by the governor with the consent of the senate. Three of the members of the review board shall be physicians from the board for professional medical conduct. Two of the members of the review board shall be lay members from the board for professional medical conduct. The chairperson shall assign appropriate staff to assist the review board.

3. All members shall serve three year terms, provided that two of the initial appointments shall serve for a term of two years and one of the initial appointments shall serve for one year.

4. Filing and determination of review. (a) The determinations of a committee on professional conduct of the state board for professional medical conduct may be reviewed by the administrative review board for professional medical conduct. Either the licensee or the department may seek a review. A notice of review must be served by certified mail upon the administrative review board and the adverse party within fourteen days of service of the determination of the committee on professional conduct of the state board for professional medical conduct. A commissioner's summary order under subdivision twelve of section two hundred thirty of this title and the penalty in any case in which annulment, suspension without stay or revocation of the licensee's

license is ordered by the committee on professional conduct shall remain in effect until the review board renders its determination. Any penalty imposed by the order of the committee on professional medical conduct, other than a penalty of annulment, suspension without stay or revocation, is stayed by the service of the notice of review upon the administrative review board and remains stayed until the review board renders its determination. All parties have thirty days from the service of the notice of review to submit briefs to the board. A notice of review shall be perfected only if a brief is timely submitted. All parties shall have seven days from the receipt of the submitted brief to file a response. All reviews shall consist of a review of the record of the hearing and submitted briefs only. A written determination of the review board must be rendered within forty-five days of the submission of briefs and a stipulated record.

(b) The review board shall review whether or not the determination and the penalty are consistent with the findings of fact and conclusions of law and whether or not the penalty is appropriate and within the scope of penalties permitted by section two hundred thirty-a of this title. The review board shall have the authority to remand a case to the committee on professional conduct for reconsideration or further proceedings.

(c) All determinations shall be based upon a majority concurrence of the administrative review board.

(d) The administrative review board shall issue an order based upon the determination of the administrative review board. Such order shall be served on all parties by certified mail.

5. Judicial review. An order of the administrative review board for professional medical conduct or a determination of a committee in which no review by the administrative review board was requested may be reviewed pursuant to the proceedings under article seventy-eight of the civil practice law and rules. Such proceeding shall be returnable before the appellate division of the third judicial department and such decisions shall not be stayed or enjoined except upon application to such appellate division after notice to the department and to the attorney general and upon a showing that the petitioner has a substantial likelihood of success. Failure to seek an order of the

administrative review board shall not be grounds for dismissal of such a proceeding.

§ 230-d. Office-based surgery. 1. The following words or phrases, as used in this section shall have the following meanings:

(a) "Accredited status" means the full accreditation by nationally-recognized accrediting agency(ies) determined by the commissioner.

(b) "Adverse event" means (i) patient death within thirty days; (ii) unplanned transfer to a hospital or emergency department visit within seventy-two hours of office-based surgery for reasons related to the office-based surgery encounter; (iii) unscheduled hospital admission or assignment to observation services, within seventy-two hours of the office-based surgery, for longer than twenty-four hours; or (iv) any other serious or life-threatening event.

(c) "Deep sedation" means a drug-induced depression of consciousness during which (i) the patient cannot be easily aroused but responds purposefully following repeated painful stimulation; (ii) the patient's ability to maintain independent ventilatory function may be impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

(d) "General anesthesia" means a drug-induced depression of consciousness during which (i) the patient is not arousable, even by painful stimulation; (ii) the patient's ability to maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function; and (iv) the patient's cardiovascular function may be impaired.

(e) "Moderate sedation" means a drug-induced depression of consciousness during which (i) the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous ventilation is adequate; and (iv) the

patient's cardiovascular function is usually maintained without assistance.

(f) "Minimal sedation" means a drug-induced state during which (i) patients respond normally to verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory and cardiovascular functions are unaffected.

(g) "Minor procedures" means (i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii) procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less than 500 cc of fat under unsupplemented local anesthesia.

(h) "Office-based surgery" means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital, as such term is defined in article twenty-eight of this chapter, excluding minor procedures and procedures requiring minimal sedation.

(i) "Licensee" shall mean an individual licensed or otherwise authorized under article one hundred thirty-one, one hundred thirty-one-B, individuals who have obtained an issuance of a privilege to perform podiatric standard or advanced ankle surgery pursuant to subdivisions one and two of section seven thousand nine of the education law.

2. Licensee practices in which office-based surgery is performed shall obtain and maintain full accredited status.

3. A licensee may only perform office-based surgery in a setting that has obtained and maintains full accredited status.

4. (a) Licensees shall report adverse events to the department's patient safety center within three business days of the occurrence of such adverse event. Licensees shall also report any suspected health care disease transmission originating in their practices to the patient safety center within three business days of becoming aware of such

suspected transmission. For purposes of this section, health care disease transmission shall mean the transmission of a reportable communicable disease that is blood borne from a health care professional to a patient or between patients as a result of improper infection control practices by the health care professional.

(b) The department may also require licensees to report additional data such as procedural information as needed for the interpretation of adverse events.

(c) The data reported under this subdivision shall be subject to all confidentiality provisions provided by section twenty-nine hundred ninety-eight-e of this chapter.

5. The commissioner shall make, adopt, promulgate and enforce such rules and regulations, as he or she may deem appropriate, to effectuate the purposes of this section. Where any rule or regulation under this section would affect the scope of practice of a health care practitioner licensed, registered or certified under title eight of the education law other than those licensed under articles one hundred thirty-one or one hundred thirty-one-B of the education law, the rule or regulation shall be made with the concurrence of the commissioner of education.

§ 230-e. Unauthorized pelvic examinations. For the purposes of this title, professional misconduct shall include pelvic examinations or supervising the performance of a pelvic examination in violation of subdivision seven of section twenty-five hundred four of this chapter.

* TITLE II-B

NEW YORK STATE HEALTH SERVICES CORPS

Section 231. New York state health service corps.

232. Powers and duties.

233. New York state health service corps scholarship and fellowship program.

* NB Expired July 18, 1996

*** § 231. New York state health service corps.** 1. The commissioner shall establish within the department the New York state health service corps (hereinafter "corps"). The commissioner shall have central responsibility for administering the provisions of this title with respect to increasing the availability of health services in certain eligible facilities and institutions.

2. For purposes of this title: (a) "health corps professional" means a nurse, physician's assistant, dental hygienist, occupational therapist, speech-language pathologist, audiologist, physical therapist, midwife or such other health professional, other than a physician or dentist, who is determined by the commissioner, in consultation with the commissioners of education, correctional services, mental health, mental retardation and developmental disabilities and the president of the civil service commission, to possess the skills and training appropriate to the needs of eligible institutions and facilities;

(b) "eligible institutions and facilities" shall include: (i) facilities operated by the department of correctional services, office of mental health and office of mental retardation and developmental disabilities; (ii) non-profit agencies possessing operating certificates issued by the office of mental health or office of mental retardation and developmental disabilities or under contract with the commission for the blind and visually handicapped; (iii) not-for-profit diagnostic and treatment centers licensed under article twenty-eight of this chapter which have a critical shortage of health personnel, as determined by the commissioner and which serve the medically indigent and medicaid eligible persons; (iv) AIDS service sites, as defined in this section; (v) health care facilities operated by the department, provided that at any time the total number of placements in such facilities shall not exceed ten percent of the total number of placements under this section; and (vi) in the case of midwives, not-for-profit facilities licensed under article twenty-eight of this chapter which serve the medically indigent and medicaid eligible women;

(c) "president" means the president of the New York state higher education services corporation.

(d) "AIDS service sites" means health care facilities and non-profit or public agencies, designated by the commissioner, which provide care

or treatment to persons infected with the human immunodeficiency virus (HIV) or who have acquired immunodeficiency syndrome (AIDS) and which are currently experiencing a shortage of health personnel to specifically serve such person.

* NB Expired July 18, 1996

* **§ 232. Powers and duties.** The commissioner shall, in consultation with the commissioners of education, correctional services, mental health, mental retardation and developmental disabilities and the president of the civil service commission, have the following powers and duties:

1. To recruit and select health corps professionals for service in eligible institutions and facilities;

2. To place health corps professionals in eligible institutions and facilities pursuant to agreements with the appropriate eligible institutions and facilities;

3. To select recipients of scholarships and fellowships authorized pursuant to section two hundred thirty-three of this title;

4. To develop criteria for the selection of students eligible for health corps scholarships or fellowships under the provisions of section two hundred thirty-three of this title, including, but not limited to, the student's academic achievement, previous work experience in their chosen health profession and a demonstrated interest in working with institutionalized populations or with persons infected with the human immunodeficiency virus (HIV) or who have acquired immunodeficiency syndrome (AIDS) or in a health care setting eligible pursuant to this title;

5. To accept and expend any grants, awards or other funds or appropriations as may be available to effectuate the purposes of this title subject to the limitations as to the approval of expenditures and audit as prescribed for state funds by the state finance law; and

6. To do any and all things necessary to carry out its functions, powers and duties and to effectuate the purposes of this title.

* NB Expired July 18, 1996

*** § 233. New York state health service corps scholarship and fellowship program.** 1. (a) New York state health service corps scholarships and fellowships for health corps professionals shall be awarded, within amounts appropriated, on a competitive basis, as determined by the commissioner, to students who: (i) are or will be enrolled in a program of undergraduate or graduate study to become a health care professional eligible to participate in the health service corps; and

(ii) agree to serve in eligible institutions or facilities upon satisfactory completion of their studies and upon satisfaction of applicable licensing and certification requirements; and

(iii) meet such other requirements as the commissioner, in consultation with the commissioners of education, correctional services, mental health, mental retardation and developmental disabilities, the commission for the blind and visually handicapped and the president of the civil service commission, may establish.

(b) In selecting students to be awarded such scholarships or fellowships, preference shall be given to students in the following order: (i) New York state residents who attend or plan to attend a program of undergraduate or graduate study located in New York state; (ii) New York state residents who attend or plan to attend a program of undergraduate or graduate study located out-of-state; and (iii) persons who are not residents of New York state who attend or plan to attend a program of undergraduate or graduate study located in New York state.

(c) The commissioner shall, pursuant to agreement with the appropriate agency, allocate, to the extent possible, the placement of award recipients to each catchment area or region, as defined by such agency, in which an eligible institution or facility is located.

2. Within such time as the commissioner shall by regulation provide, a recipient of an award shall have practiced as a health corps

professional in an eligible institution or facility for that number of months calculated by multiplying by eighteen the number of annual awards received by the recipient. If a recipient fails to comply fully with such conditions, the president shall be entitled to receive from such recipient an amount to be determined by the formula:

$$A = \frac{2B(T-S)}{t}$$

In which "A" is the amount the president is entitled to recover; "B" is the sum of all payments made to the recipient and the interest on such amount which would be payable if at the times such awards were paid they were loans bearing interest at the maximum prevailing rate; "t" is the total number of months in the recipient's period of obligated services; and "s" is the number of months of service actually rendered by the recipient. Any amount which the president is entitled to recover under this subdivision shall be paid within the five-year period beginning on the date that the recipient failed to comply with this condition. Any obligation to comply with such provisions shall be cancelled upon the death of the recipient. The commissioner of health shall promulgate regulations to provide for the waiver or suspension of any financial obligation when compliance would involve extreme hardship.

3. A recipient of an award shall report semi-annually to the president, on forms prescribed by him, as to the performance of the required services or the recipient's current status, commencing with the calendar year of the first award and continuing until the recipient shall have completed, or until it is determined he or she shall not be obligated to complete, the required services. The president may also require the recipient to file a report on his or her current status prior to completion of professional training during any calendar year in which an application for an additional award is not filed. The president shall make available any reports required hereunder to the commissioner. If the recipient shall fail to file any report required hereunder within thirty days of written notice to the recipient, mailed to the address shown on the last application for an award or last report filed, whichever is later, the president may impose a fine of up to one thousand dollars. The president shall have the discretion to waive the filing of a report, excuse a delay in filing, or a failure to file a

report, or waive or reduce any fine imposed for good cause shown.

* NB Expired July 18, 1996

TITLE II-C

CHARLES D. COOK OFFICE OF RURAL HEALTH

Section 234. Legislative findings and intent.

235. Definitions.

236. Charles D. Cook office of rural health created.

236-a. Study of health professional employment incentives.

236-b. Rural health council.

237. Preparation and distribution of reports.

§ 234. Legislative findings and intent. The legislature hereby finds, determines, and declares that:

1. There is a necessity to address different approaches to rural health care delivery in the state. These approaches need to support diverse community and individual needs including unique rural conditions such as low population density, a large proportion of elderly, geographic isolation, inadequate transportation, absence of economies of scale, as well as fluctuating and limited service demands.

2. It is often difficult for small, rural health care providers to obtain timely information on rural programs. Also, it is often burdensome for these providers to locate the resources to apply for aid from programs which exist to support rural health care services delivery.

3. Both private and public sectors have begun to recognize the urgency for programs that address the unique nature of rural health care access and service delivery. New rural health care programs have been established, however, these programs are administered by several organizations and municipalities. Coordination is essential to maximize their potential impact on the rural community.

4. Rural health care providers would greatly benefit if there were a single office within the department which would coordinate the administration and flow of information on rural health programs by promoting innovative and improved approaches to rural health care delivery.

§ 235. Definitions. For the purposes of this article:

1. "Rural area" shall mean a county with a population of two hundred thousand persons or less, or a town with a population density of one hundred fifty persons or less per square mile.

2. "Rural health care provider" or "rural provider" shall mean any agency, corporation, facility, or individual providing medical and/or health care services to residents of a rural area.

3. "Office" shall mean the Charles D. Cook office of rural health, as created pursuant to section two hundred thirty-six of this article.

4. "Rural health council" shall mean the rural health council established pursuant to section two hundred thirty-six-b of this title.

§ 236. Charles D. Cook office of rural health created. There is hereby created the Charles D. Cook office of rural health within the state department of health. Such office shall:

1. Integrate and coordinate selected state health care grant and loan programs established specifically for rural health care providers and residents. As part of this function, the office shall develop a coordinated application process for use by rural providers, municipalities and others in seeking funds and/or technical assistance on pertinent rural health care programs and services. The office shall also work to promote the usage of the Rural Assistance Information Network (RAIN) to assist rural providers and others in obtaining information on funding and/or technical assistance for rural health care

programs and services.

2. Apply for grants, and accept gifts from private and public sources for research to improve and enhance rural health care services and facilities. The office shall also promote rural health research in universities and colleges.

3. Together with the rural health council, serve as liaison and advocate for the department on rural health matters. This function shall include the provision of staff support to the rural health council and the establishment of appropriate program linkages with related federal, state, and local agencies and programs such as the office of rural affairs, the agricultural extension service and migrant health services.

4. Assist medical schools and state agencies to develop comprehensive programs to improve rural health personnel supply by promoting rural clinical training and curriculum improvement, and disseminating rural health career information to high school and college students.

5. Promote community strategic planning or new or improved health care delivery systems and networks in rural areas. Strategic network planning and development may include such considerations as personnel, capital facilities, reimbursement, primary care, long term care, acute care, rehabilitative, preventive, and related services on the health continuum.

6. Review the impact of programs, regulations, and health care reimbursement policies on rural services delivery and access.

§ 236-a. Study of health professional employment incentives. 1. The legislature hereby finds and declares that:

a. Some parts of rural New York are suffering from physician and nurse practitioner shortages forcing residents to forego proper care or travel long distances to receive health care. Rural areas have particular characteristics such as low population density, inadequate

transportation, increasing elderly population, and a lack of economies of scale. These issues make recruiting and retaining physicians and nurse practitioners in rural areas more challenging than in suburban and urban settings.

b. Therefore it is incumbent upon the state to provide incentives and assistance to physicians and nurse practitioners willing to practice in these shortage areas.

2. The Charles D. Cook office of rural health, in consultation with the rural health council, is hereby authorized and directed to conduct a study to analyze incentive options to encourage physicians and nurse practitioners to practice in rural, underserved areas. The report shall contain, but not be limited to, evaluations of the following incentive options: high needs service bonuses, signing bonuses, tax credits, small business assistance for beginning practices, programs designed to recruit high school students, and rural medical education tracks in medical schools. The report shall contain an analysis of current state level loan repayment programs and their effectiveness and may consider any similar local programs. The report shall also provide information on federal programs and their impact on New York state rural physician and nurse practitioner recruitment. The study shall make recommendations as to which incentives are the most effective in recruitment and retention of such health professionals.

3. The director of the Charles D. Cook office of rural health is hereby directed to prepare and present to the legislature, on or before March first of the year next succeeding the effective date of this section, a report containing a summary of its findings and recommendations.

§ 236-b. Rural health council. 1. There shall be established within the office a rural health council to be composed of twenty-one members who shall be appointed by the governor, with ten of these members appointed as follows:

- a. four members upon the recommendation of the temporary president of the senate;
- b. one member upon the recommendation of the minority leader of the senate;
- c. four members upon the recommendation of the speaker of the assembly; and
- d. one member upon the recommendation of the minority leader of the assembly.

Vacancies in the membership of such council shall be filled by the appropriate appointing authority. The governor shall select a chairperson from among the members of the council. The members of the council shall be reflective of the state's rural areas, as defined in subdivision seven of section four hundred eighty-one of the executive law, and shall include representatives of health care providers that comprise the health care delivery system in the state's rural areas, individuals with expertise in clinical and administrative aspects of health care delivery, health care financing and reimbursement, health care regulation, public health, health planning, health workforce education, and behavioral health.

2. The rural health council shall be responsible for advising the commissioner with respect to all aspects of rural health care and rural health care delivery including, but not limited to, the impact of proposed programs, statutes, regulations and health care reimbursement policies. The rural health council shall also assist the office with its responsibilities as delineated in section two hundred thirty-six of this title; contribute to the biennial report required pursuant to section two hundred thirty-seven of this title, and act as liaison and advocate on rural health matters.

3. The rural health council shall recommend to the department cost-effective ways to obtain timely data on the status of the health care workforce supply in rural areas. At least once every three years

the rural health council shall, in conjunction with the office, submit a report to the regional economic development councils on the status of the health care workforce supply in their respective regions to the extent data on the health care workforce supply is available.

4. Staff support for the rural health council shall be provided for by the office as provided for in section two hundred thirty-six of this title.

5. The rural health council shall meet as frequently as its business may require, but not less than two times a year. Meetings may be called by the chairperson at the request of the commissioner.

6. The entirety of each meeting of the rural health council shall be live webcast to the public on the department's website, and archived on the department's website, for a period of no less than two years, within twenty-four hours of the adjournment of the last meeting. The department shall provide notice to the public, via the department's website, of the availability of the live webcast of each such meeting.

7. The members of the rural health council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties hereunder.

§ 237. Preparation and distribution of reports. The department shall submit a biennial report to the governor and the legislature describing the activities of the office and health status of rural areas. The first such report shall be transmitted on or before September first, nineteen hundred ninety-three. Such report shall contain the following information:

1. Activities of the Charles D. Cook office of rural health, expenditures incurred in carrying out such activities, and anticipated activities to be undertaken in the future;

2. Progress in carrying out the functions and duties listed in section two hundred thirty-six of this article.

3. An analysis of the health status of rural citizens and the status of rural health delivery systems. Such analysis shall be conducted in cooperation with the rural health council and other interested agencies.

4. Any recommended improvements to programs and/or regulations that would enhance the cost effectiveness of the office, and programs intended to meet the health care needs of rural residents.

5. Notwithstanding any other provision of law to the contrary, such biennial report may also incorporate the reporting requirements for cooperative programs and networks for health care delivery in underserved rural areas as required by section twenty-nine hundred fifty-three of the public health law.

TITLE II-D

HEALTH CARE PRACTITIONER REFERRALS

Section 238. Definitions.

238-a. Prohibition of financial arrangements and referrals.

238-b. Provider requests for payment.

238-c. Provider reporting requirements.

238-d. Practitioner disclosure requirements.

238-e. Study of referrals by practitioners.

§ 238. Definitions. As used in this title, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Clinical laboratory services" shall mean the microbiological, serological, chemical, hematological, biophysical, cytological or pathological examination of materials derived from the human body, for the purposes of obtaining information for the diagnosis, prevention, or treatment of disease or the assessment of health condition.

2. "Fair market value" shall mean the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

3. "Financial relationship" shall mean an ownership interest, investment interest or compensation arrangement.

4. "General hospital" shall have the same meaning as is set forth in subdivision ten of section twenty-eight hundred one of this chapter.

5. "Group practice" shall mean a group of two or more practitioners organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan or similar association; and

(a) in which each practitioner who is a member of the group provides substantially the full range of services which the practitioner routinely provides, including medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment and personnel; and

(b) for which substantially all of the services of the practitioners who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

(c) in which the overhead expenses of the income from the practice are distributed in accordance with methods previously determined by members of the group; and

(d) provided, however, in the case of a faculty practice plan associated with a hospital with an approved residency training program in which practitioner members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, the

provisions of paragraphs (a), (b) and (c) of this subdivision shall be applied only with respect to the services provided within the faculty practice plan.

6. "Health care provider" shall mean a practitioner in an individual practice, group practice, partnership, professional corporation or other authorized form of association, a hospital or other health care institution issued an operating certificate pursuant to this chapter or the mental hygiene law, a certified home health agency or a licensed home care services agency, and any other purveyor of health or health related items or services including but not limited to a clinical laboratory, a physiological laboratory, a pharmacy, a purveyor of x-ray or imaging services, a purveyor of physical therapy services, a purveyor of health or health related supplies, appliances or equipment, or an ambulance service.

7. "Health or health related items or services" shall include, but not be limited to, items and services available under the medical assistance program pursuant to title eleven of article five of the social services law.

8. "Immediate family member" shall include spouse; birth and adoptive parents, children and siblings; stepparents, stepchildren and stepsiblings; fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, sons-in-law and daughters-in-law; and grandparents and grandchildren.

9. "Interested investor" shall mean, with respect to a health care provider, an investor who is a practitioner in a position to make or to influence referrals or business to the health care provider, or who is an immediate family member of such an investor.

10. "Investor" shall mean, with respect to a health care provider, a person with a financial relationship with the health care provider, subject to the exceptions provided in paragraph (b) of subdivision three, subdivision four and paragraph (b) of subdivision five of section two hundred thirty-eight-a of this title.

11. "Practitioner" shall mean a licensed or registered physician, dentist, podiatrist, chiropractor, nurse, midwife, physician assistant or specialist assistant, physical therapist, or optometrist.

12. "Rural" shall mean (i) a county with a population of two hundred thousand persons or less, or a town with a population density of one hundred fifty persons or less per square mile; and (ii) other rural areas pursuant to standards promulgated in regulation by the commissioner.

13. "X-ray or imaging services" shall mean diagnostic imaging techniques which shall include but not be limited to the following:

- (a) Conventional x-ray or radiology.
- (b) Fluoroscopy.
- (c) Digital radiography.
- (d) Computed tomography.
- (e) Magnetic resonance imaging.
- (f) Nuclear imaging.
- (g) Ultrasonography.
- (h) Angiography.

14. "Pharmacy services" shall mean the preparing, compounding, preserving or, the dispensing of drugs, medicines and therapeutic devices on the basis of prescriptions or other legal authority.

15. "Radiation therapy services" shall mean the use of high energy x-rays, particles, or radiation materials for the treatment of cancer and other diseases.

16. "Physical therapy services" means physical therapy as defined by section sixty-seven hundred thirty-one of the education law.

17. "Public health council" shall mean the public health and health planning council.

§ 238-a. Prohibition of financial arrangements and referrals. 1. (a)

A practitioner authorized to order clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services may not make a referral for such services to a health care provider authorized to provide such services where such practitioner or immediate family member of such practitioner has a financial relationship with such health care provider.

(b) A health care provider or a referring practitioner may not present or cause to be presented to any individual or third party payor or other entity a claim, bill, or other demand for payment for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by this subdivision.

2. Subdivision one of this section shall not apply in any of the following cases:

(a) practitioners' services - in the case of practitioners' services provided personally by, or under the supervision of, another practitioner in the same group practice as the referring practitioner;

(b) in-office ancillary services - in the case of health or health related items or services (i) that are furnished personally by the referring practitioner, personally by a practitioner who is a member of the same group practice as the referring practitioner, or personally by individuals who are employed by such practitioner or group practice and who are supervised by the practitioner or by another practitioner in the group practice; and in a building in which the referring practitioner, or another practitioner who is a member of the same group practice, furnishes practitioners' services unrelated to the furnishing of such items or services, or in the case of a referring practitioner who is a member of a group practice, in another building which is used by the group practice for the centralized provision of such items or services of the group; and (ii) that are billed by the practitioner performing or supervising the services, by a group practice of which such practitioner is a member, or by an entity that is wholly owned by such practitioner or such group practice;

(c) in the case of health or health related items or services furnished to subscribers of a health maintenance organization operating

pursuant to article forty-three of the insurance law or article forty-four of this chapter, participants in a managed care program operating pursuant to section three hundred sixty-four-j of the social services law or persons enrolled in a prepaid health services plan authorized by law;

(d) in the case of a referral for inpatient hospital services, including services by hospital staff practitioners provided in the hospital;

(e) in the case of a referral of a hospital inpatient, outpatient or emergency services patient for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services provided by the hospital, including services by hospital staff practitioners provided in the hospital;

(f) in the case of a financial relationship with a general hospital if the financial relationship does not relate specifically to the provision of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services for which the referral was made; and

(g) in the case of any other financial relationship which the public health council determines and specifies in regulations, subject to approval by the commissioner, does not pose a substantial risk of payor or patient abuse in relation to patient benefits consistent, to the extent practicable, with financial relationships specified in regulations adopted pursuant to federal law applicable to reimbursement pursuant to title XVIII of the federal social security act (medicare) for clinical laboratory services provided to beneficiaries of title XVIII of the federal social security act (medicare).

3. For the purposes of this section, an ownership interest or an investment interest:

(a) may be through equity, debt or other means; but

(b) shall not include ownership of investment securities, including shares or bonds, debentures, notes or other debt instruments, which were purchased on terms generally available to the public and which are in a corporation that is listed for trading on the New York stock exchange or on the American stock exchange, or is a national market system security traded under an automated interdealer quotation system operated by the

national association of securities dealers, and had, at the end of the corporation's most recent fiscal year, total assets exceeding one hundred million dollars or to the extent such ownership would be permitted by federal law or regulation if the services rendered were clinical laboratory services provided to beneficiaries of title XVIII of the federal social security act (medicare).

4. An ownership interest or an investment interest shall not be subject to subdivision one of this section if:

(a) the health care provider authorized to provide clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services is in a rural area and the referring practitioner or the patient is in such rural area; or

(b) the clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services are provided by a general hospital, the referring practitioner is authorized to perform services at such general hospital and the ownership or investment interest is in the general hospital itself and not merely in a subdivision thereof; or

(c) the clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services are provided by an ambulatory surgical center issued an operating certificate pursuant to article twenty-eight of this chapter in conjunction with a surgical procedure performed by the referring practitioner at the ambulatory surgical center;

(d) and if each practitioner who is an interested investor in a health care provider within a category specified in paragraph (a), (b) or (c) of this subdivision and who makes a referral of a patient to such health care provider discloses to the patient, in a brief and reasonable form and manner specified in regulations proposed by the commissioner after consultation with representatives of consumer and physician organizations and adopted by the public health council, subject to approval by the commissioner, the practitioner's, or family member's ownership interest or investment interest in the health care provider and the patient's right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available.

5. (a) For the purposes of this section, a compensation arrangement means any arrangement involving any remuneration between a practitioner, or immediate family member, and a health care provider. The term remuneration includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(b) For the purposes of this section a compensation arrangement shall not include:

(i) payments made for the rental or lease of office space, if (A) there is a written agreement, signed by the parties, for the rental or lease of the space, which agreement specifies the space covered by the agreement and dedicated for the use of the lessee, provides for a term of rental or lease of at least one year, provides for a payment on a periodic basis of an amount that is consistent with fair market value, provides for an amount of aggregate payments that does not vary, directly or indirectly, based on the volume or value of any referrals of business between the parties, and would be considered to be commercially reasonable even if no referrals were made between the parties; or (B) in the case of rental or lease of office space in which a practitioner who is an interested investor, or an interested investor who is an immediate family member of the practitioner, has an ownership or investment interest, the office space is in the same building as the building in which the practitioner or group practice of which the practitioner is a member has a practice;

(ii) an arrangement between a general hospital and a practitioner, or immediate family member, for the employment of the practitioner, or immediate family member, or for the provision of administrative services, if the arrangement is for identifiable services, the amount of remuneration under the arrangement is consistent with the fair market value of the services, the remuneration is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring practitioner and such remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the general hospital;

(iii) an arrangement between a health care provider other than a general hospital and a practitioner if (A) the arrangement is for specific identifiable services as the medical director or as a member of a medical advisory board at the provider, for specific identifiable

practitioner services to be furnished to an individual receiving hospice care payable as hospice care, for specific practitioners' services furnished to a non-profit blood center, or for specific identifiable administrative services, other than direct patient care services, but only under exceptional circumstances; and (B) the amount of remuneration under the arrangement is consistent with the fair market value of the services, the remuneration is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring practitioner and such remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made;

(iv) remuneration which is provided by a general hospital to a practitioner to induce the practitioner to relocate to the geographic area served by the general hospital in order to be a member of the medical staff of the general hospital if the practitioner is not required to refer patients to the hospital and the amount of the remuneration under the arrangement is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals by the referring practitioner;

(v) an isolated financial transaction, such as a one-time sale of property, if the amount of remuneration under the arrangement is consistent with the fair market value, the remuneration is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring practitioner and such remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made;

(vi) a compensation arrangement involving payment by a group practice of the salary of a practitioner member of the group practice;

(vii) and provided that any arrangement specified in subparagraphs (i) through (vi) of this paragraph meets such other requirements as the public health council may impose by regulation, subject to approval by the commissioner, as needed to protect against payor or patient abuse consistent with requirements imposed by regulations adopted pursuant to federal law applicable to reimbursement pursuant to title XVIII of the federal social security act (medicare) for clinical laboratory services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(viii) an arrangement between a health care provider and an immediate family member of a practitioner for the employment of the immediate family member which the commissioner determines on application by the parties does not pose a substantial risk of payor or patient abuse in relation to patient benefits subject to such requirements as the commissioner shall determine necessary to protect the public interest, and which for a clinical laboratory that provides services to beneficiaries to title XVIII of the federal social security act (medicare) qualifies for an exception from the prohibitions on such compensation arrangements for purposes of reimbursement of clinical laboratory services pursuant to title XVIII of the federal social security act (medicare). Such application shall be in a form and content specified by the commissioner after consultation with representatives of consumer and physician organizations. The commissioner shall make such determination within sixty days of receipt of a complete application.

6. For the purposes of this title:

(a) in the case of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services, the request by a practitioner for such services, including the request by a practitioner for a consultation with another practitioner, and any test or procedure ordered by, or to be performed by or under the supervision of that other practitioner, shall constitute a referral by a referring practitioner; and

(b) in the case of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services, the request or establishment of a plan of care by a practitioner which includes the provision of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services shall constitute a referral by a referring practitioner;

(c) provided further, however, that the following shall not constitute a referral by a referring practitioner:

(i) a request by a practitioner for practitioners' services consisting solely of professional services to be furnished personally by that practitioner, or under that practitioner's supervision;

(ii) a request by a pathologist for clinical diagnostic laboratory

tests and pathological examination services, if such services are furnished by or under the supervision of such pathologist pursuant to a consultation requested by another practitioner; and

(iii) a request by a radiologist for diagnostic x-ray or imaging services, if such services are furnished by or under the supervision of such radiologist pursuant to a consultation requested by another practitioner.

7. If a referring practitioner or a health care provider furnishing clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services or any other person or entity collects any amounts that were billed in violation of this section, such referring practitioner and health care provider and other person or entity shall be jointly and severally liable to the payor for any amounts so collected.

8. Each health care provider furnishing clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services shall submit such information as reasonably may be required by the department for purposes of this title.

9. Subdivision one of this section shall apply to an arrangement or scheme, such as a cross-referral arrangement, which the practitioner or health care provider knows or should know has a principal purpose of assuring referrals by the practitioner for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services to a particular health care provider which, if the practitioner directly made referrals to such health care provider, would be in violation of subdivision one of this section.

10. The public health council shall adopt rules and regulations, subject to approval by the commissioner, necessary to effectuate the provisions and purposes of this title.

§ 238-b. Provider requests for payment. Each request for payment or bill submitted by a health care provider for clinical laboratory,

pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services for which the provider knows or has reason to believe that there has been a referral by a referring practitioner who is an interested investor in the health care provider shall identify the referring practitioner by name and by professional license number or any appropriate program provider number. The provisions of this section shall not apply to requests for payment or bills the content of which are regulated solely by federal law or regulation and to services excluded pursuant to paragraph (a), (b), (c), (d) or (e) of subdivision two of section two hundred thirty-eight-a of this title from the prohibitions of subdivision one of section two hundred thirty-eight-a of this title.

§ 238-c. Provider reporting requirements. Each health care provider providing clinical laboratory, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services shall report to the commissioner in writing every two years information concerning the provider's ownership arrangements, including the health or health related items or services provided by the provider and the names and professional license numbers or any appropriate program provider numbers of practitioners with an ownership or investment interest in the provider, or whose immediate relatives have such an ownership or investment. The information required to be reported to the commissioner pursuant to this section to the extent practicable shall be consistent with the information required pursuant to federal law and regulations to be reported to the secretary of health and human services for health care providers providing items or services to beneficiaries of title XVIII of the federal social security act (medicare). The commissioner shall consult with the commissioner of social services to avoid duplication of reporting requirements for health care providers that participate in the medical assistance program pursuant to title eleven of article five of the social services law.

§ 238-d. Practitioner disclosure requirements. 1. With respect to referrals not prohibited pursuant to this title, and except as provided

in subdivision three of this section, a practitioner may not make a referral to a health care provider for the furnishing of any health or health related items or services where such practitioner or immediate family member of such practitioner has any of the following financial relationships without disclosing to the patient such financial relationship:

(a) an ownership or investment interest, as defined in subdivision three of section two hundred thirty-eight-a of this title, with such health care provider; or

(b) a compensation arrangement, as defined in subdivision five of section two hundred thirty-eight-a of this title, with such health care provider which is in excess of fair market value or which provides for compensation that varies directly or indirectly based on the volume or value of any referrals of business between the parties.

2. The disclosure shall provide notice of any such financial relationship and shall also inform the patient of his or her right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available, and shall be provided in a brief and reasonable form and manner specified in regulations proposed by the commissioner in consultation with consumer and physician organizations and adopted by the public health council, subject to approval by the commissioner.

3. Disclosure pursuant to this section shall not be required for a referral for the furnishing of any health or health related items or services under circumstances for which a referral of clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services would not be prohibited pursuant to section two hundred thirty-eight-a of this title, provided that any disclosure required by section two hundred thirty-eight-a of this title remains applicable.

§ 238-e. Study of referrals by practitioners. 1. The commissioner may conduct a study of the ownership of or financial interests in health care providers by referring practitioners. Such study shall investigate:

(a) the types of such ownership arrangements and types of services offered under such arrangements; (b) the effect of such arrangements on the utilization of health or health related items and services; and (c) the effect of such arrangements on independent providers of similar services.

2. For the purposes of the study authorized by this section, the commissioner is authorized to request and any health care provider or practitioner shall provide, such information regarding those matters which the commissioner is authorized to study pursuant to subdivision one of this section in such form as may be prescribed by the commissioner.

3. Patient and practitioner identifying information collected pursuant to this section shall be confidential and not subject to disclosure.

TITLE II-E

HIV/HBV/HCV PREVENTION TRAINING

Section 239. Course work or training in infection control practices.

239-a. Infection control guidelines.

239-b. Study on multidose vials and disposable medical equipment.

§ 239. Course work or training in infection control practices. (a) Every physician, physician assistant and specialist assistant practicing in the state shall, on or before July first, nineteen hundred ninety-four and every four years thereafter, complete course work or training, appropriate to the professional's practice, approved by the department regarding infection control, which shall include sepsis, and barrier precautions, including engineering and work practice controls, in accordance with regulatory standards promulgated by the department in consultation with the department of education, to prevent the transmission of HIV, HBV, HCV and infections that could lead to sepsis in the course of professional practice. Such coursework or training must also be completed by every medical student, medical resident and

physician assistant student in the state as part of the orientation programs conducted by medical schools, medical residency programs and physician assistant programs.

(b) Every physician, physician assistant, specialist assistant, medical student, medical resident and physician assistant student must provide to the department documentation demonstrating the completion of and competence in the coursework or training required under subdivision (a) of this section, provided however, that physicians subject to the provisions of paragraph (f) of subdivision one of section twenty-eight hundred five-k of this chapter shall not be required to provide such documentation to the department.

(c) The department shall provide an exemption from the requirements imposed by subdivision (a) of this section to anyone who requests such an exemption and who (i) clearly demonstrates to the department's satisfaction that there would be no need for him or her to complete such course work or training because of the nature of his or her practice or (ii) that he or she has completed course work or training deemed by the department to be equivalent to the standards for course work or training approved by the department pursuant to this section. An individual granted an exemption must reapply to continue such exemption every four years.

(d) The department shall consult with organizations representative of professions, institutions and those with expertise in infection control and HIV, HBV, and HCV with respect to the regulatory standards promulgated pursuant to this section. On or before September first, two thousand eight, and periodically thereafter as determined necessary by the commissioner, the department, including its patient safety center, in consultation with the council on graduate medical education, shall review and revise the content of the coursework or training in infection control practices as necessary to ensure that such content: (i) reflects the current infection control practices and standards accepted and promoted by the medical and scientific communities; (ii) focuses particular attention on instruction in standards of practice for which compliance is suboptimal based on the department's experience; and (iii) emphasizes the application of infection control standards and practices in outpatient and ambulatory settings.

§ 239-a. Infection control guidelines. The commissioner shall develop evidence-based guidelines that identify key infection control practices in inpatient and outpatient medical care settings. Such guidelines shall specifically cover safe injection practices. On or before January first, two thousand nine, and every year thereafter, the department will distribute these guidelines to physicians, specialist assistants and physician assistants. Such guidelines shall also be made publicly available.

§ 239-b. Study on multidose vials and disposable medical equipment. The department shall conduct a study on medications packaged in multidose vials and disposable medical equipment, including but not limited to syringes, needles, stopcocks and tubing. Such study shall examine:

1. existing utilization patterns of multidose vials and disposable medical equipment;
2. the potential to improve infection control practices by restricting the use of multidose vials and mandating the use of disposable medical equipment engineered for single use; and
3. the viability of restricting the use of multidose vials and mandating the use of disposable medical equipment engineered for single use. On or before January first, two thousand nine, the commissioner shall provide the governor, the speaker of the assembly, the temporary president of the senate, and the chairpersons of the assembly and senate health committees with a report setting forth the conclusions of the study and the commissioner's recommendations regarding multidose vials and disposable medical equipment.

TITLE II-F

OFFICE OF HEALTH EQUITY

Section 240*2. Definitions.

241*2. Office of minority health created.

242*2. Preparation and distribution of reports.

243*2. Minority health council.

244. Transgender and non-binary (TGNB) wellness and equity program.

*** § 240. Definitions.** For the purposes of this article:

1. "Underserved populations" shall mean those who have experienced injustices and disadvantages as a result of their race, ethnicity, sexual orientation, gender identity, gender expression, disability status, age, immigration status, and/or socioeconomic status, among others as determined by the commissioner of health.

2. "Racially and ethnically diverse area" shall mean a county with a non-white population of forty percent or more, or the service area of an agency, corporation, facility or individual providing medical and/or health services whose non-white population is forty percent or more.

3. "Provider" shall mean any agency, corporation, facility, or individual providing medical and/or health care services to underserved populations.

4. "Office" shall mean the office of health equity, as created pursuant to section two hundred forty-one of this title.

5. "Health equity council" shall mean that advisory body to the commissioner, created pursuant to the provisions of section two hundred forty-three of this title.

6. "Health disparities" shall mean measurable differences in health status, access to care, and quality of care as determined by race, ethnicity, sexual orientation, gender identity, a preferred language other than English, gender expression, disability status, aging population, immigration status, and socioeconomic status.

7. "Health equity" shall mean achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socioeconomic disadvantages, and systemic disadvantages.

8. "Social determinants of health" shall mean life-enhancing resources, such as availability of healthful foods, quality housing, economic opportunity, social relationships, transportation, education, and health care, whose distribution across populations effectively determines the length and quality of life.

* NB There are 2 § 240's

*** § 241. Office of health equity created.** There is hereby created an office of health equity within the state department of health. Such office shall:

1. Work collaboratively with other state agencies and affected stakeholders, including providers and representatives of underserved populations, in order to set priorities, collect and disseminate data, and align resources within the department and across other state agencies. The office shall also conduct health promotion and educational outreach, as well as develop and implement interventions aimed at achieving health equity among underserved populations by implementing strategies to address the varying complex causes of health disparities, including the economic, physical, and social environments.

2. Integrate and coordinate selected state health care grant and loan programs established specifically for promoting health equity in New York state. As part of this function, the office shall develop a coordinated application process for use by providers, municipalities and others in seeking funds and/or technical assistance on pertinent programs and services targeted to address health equity among underserved populations.

3. Apply for grants, and accept gifts from private and public sources

for research to improve and enhance health equity. The office shall also promote health equity research in universities and colleges.

4. Together with the health equity council, serve as liaison and advocate for the department on health equity matters. This function shall include the provision of staff support to the health equity council and the establishment of appropriate program linkages with related federal, state, and local agencies and programs such as the office of health equity of the public health service, the agricultural extension service and migrant health services.

5. Assist medical schools and state agencies to develop comprehensive programs to improve the diversity of health personnel workforce by promoting health equity clinical training and curriculum improvement, and disseminating health career information to high school and college students.

6. Promote community strategic planning to address the complex causes of health disparities, including the social determinants of health and health care delivery systems and networks, in order to improve health equity. Strategic network planning and development may include such considerations as healthful foods, quality housing, economic opportunity, social relationships, transportation, and education, as well as health care systems, including associated personnel, capital facilities, reimbursement, primary care, long-term care, acute care, rehabilitative, preventive, and related services on the health continuum.

7. Review the impact of programs, regulations, and policies on health equity.

* NB There are 2 § 241's

*** § 242. Preparation and distribution of reports.** The department shall submit a biennial report to the governor and the legislature describing the activities of the office and health status of minority areas. The first such report shall be transmitted on or before September first,

nineteen hundred ninety-four. Such report shall contain the following information:

1. Activities of the office of health equity, expenditures incurred in carrying out such activities, and anticipated activities to be undertaken in the future.

2. Progress in carrying out the functions and duties listed in section two hundred forty-one of this title.

3. An analysis of the health status of underserved populations, including those populations within racially and ethnically diverse areas, and the status of health delivery systems serving those communities. Such analysis shall be conducted in cooperation with the health equity council and other interested agencies.

4. Any recommended improvements to programs and/or regulations that would enhance the cost effectiveness of the office, and programs intended to meet the health and health care needs of underserved populations.

* NB There are 2 § 242's

*** § 243. Health equity council.** 1. Appointment of members. There shall be established in the office of health equity a health equity council to consist of the commissioner and fourteen members to be appointed by the governor with the advice and consent of the senate. Membership on the council shall be reflective of the diversity of the state's population including, but not limited to, the various underserved populations throughout the state.

2. Terms of office; vacancies. a. Unless specified otherwise in the bylaws of the health equity council, the terms of office of members of the health equity council may be up to six years. The members of the health equity council shall continue in office until the expiration of their terms and until their successors are appointed and have qualified. Such appointments shall be made by the governor, with the advice and

consent of the senate, within one year following the expiration of such terms.

b. Vacancies shall be filled by appointment by the governor for the unexpired terms within one year of the date upon which such vacancies occur. Any vacancy existing on the effective date of paragraph c of this subdivision shall be filled by appointment within one year of such effective date.

c. In making appointments to the council, the governor shall seek to ensure that membership on the council reflects the diversity of the state's population including, but not limited to the various underserved populations throughout the state.

3. Meetings. a. The health equity council shall meet as frequently as its business may require, and at least twice in each year.

b. The governor shall designate one of the members of the public health and health planning council as its chair.

c. A majority of the appointed voting membership of the health equity council shall constitute a quorum.

4. Compensation and expenses. The members of the council shall serve without compensation other than reimbursement of actual and necessary expenses.

5. Powers and duties. The health equity council shall, at the request of the commissioner, consider any matter relating to the preservation and improvement of health status among the state's underserved populations, and may advise the commissioner on any recommendations relating to the preservation and improvement of health equity.

6. Sickle cell disease. a. The health equity council shall consider, and advise the commissioner regarding sickle cell disease.

b. The council shall issue recommendations to the commissioner to

promote screening and detection of sickle cell disease, especially among unserved or underserved populations; to educate the public regarding sickle cell disease and the benefits of early detection; and to provide counseling and referral services. For purposes of this subdivision, "unserved or underserved populations" means people having inadequate access and financial resources to obtain sickle cell disease screening and detection services, including people who lack health coverage or whose health coverage is inadequate or who cannot meet the financial requirements of their coverage for accessing detection services.

c. The council shall consider the feasibility of the following:

(i) the establishment of a statewide public education and outreach campaign to publicize evidence based sickle cell disease screening, detection and education services. The campaign shall include: general community education, outreach to specific underserved populations, evidence based clinical sickle cell disease screening services, and an informational summary that shall include an explanation of the importance of clinical examinations and what to expect during clinical examinations and sickle cell disease screening services;

(ii) the provision of grants to approved organizations;

(iii) the compilation of data concerning sickle cell disease and dissemination of such data to the public; and

(iv) the development of health care professional education programs including the benefits of early detection of sickle cell disease and clinical examinations, the recommended frequency of clinical examinations and sickle cell disease screening services, and professionally recognized best practices guidelines.

* NB There are 2 § 243's

§ 244. Transgender and non-binary (TGNB) wellness and equity program.

1. The department, through the AIDS institute, shall establish and operate a transgender and non-binary (TGNB) wellness and equity program as authorized pursuant to this section. Such program shall be established by April first, two thousand twenty-three.

2. The transgender and non-binary (TGNB) wellness and equity program

shall be designed to:

(a) Increase the capacity of grassroots organizations working at the local level and ensure New York state invests in organizations serving transgender, gender nonconforming, non-binary and intersex individuals.

(b) Increase transgender, gender nonconforming, non-binary and intersex cultural competence by investing in cultural competency programs or curriculums that are designed by, or in consultation with, transgender, gender nonconforming, non-binary and intersex individuals.

(c) Address inequities in current funding distribution for organizations serving transgender, gender nonconforming, non-binary and intersex individuals, including but not limited to organizations located outside of the city of New York.

(d) Enable unemployed transgender, gender nonconforming, non-binary and intersex residents of New York to become gainfully employed taxpayers through job training and job placement services provided by organizations serving transgender, gender nonconforming, non-binary and intersex individuals.

(e) Foster new and emerging transgender, gender nonconforming, non-binary and intersex leadership through capacity building support.

(f) Decrease homelessness and increase access to social services by investing in organizations primarily serving transgender, gender nonconforming, non-binary and intersex individuals and that provide housing solutions dedicated to transgender, gender nonconforming, non-binary and intersex individuals.

3. Subject to appropriation, moneys in the transgender and non-binary (TGNB) wellness and equity program fund, pursuant to section ninety-five-k of the state finance law, may be used for the following purposes:

(a) Identifying community-based organizations involving and serving transgender, gender nonconforming, non-binary and intersex individuals and providing them with grants to expand their existing work involving and serving transgender, gender nonconforming, non-binary and intersex individuals.

(b) Providing grants to organizations involving and serving transgender, gender nonconforming, non-binary and intersex individuals to create supportive housing solutions and to identify, assist, and

refer transgender, gender nonconforming, non-binary and intersex residents of New York state to supportive housing.

(c) Creating or funding existing programs serving transgender, gender nonconforming, non-binary and intersex individuals that primarily coordinate inclusive health care for individuals who identify as transgender, gender nonconforming, non-binary or intersex.

(d) Providing grants to organizations involving and serving transgender, gender nonconforming, non-binary and intersex individuals to increase the capacity of health care professionals to effectively provide gender affirming care. This includes the creation of educational materials or facilitation of capacity building training.

(e) Providing grants for behavioral health services developed by, or in consultation with, transgender, gender nonconforming, non-binary and intersex individuals that offer mental health and substance use services for transgender, gender nonconforming, non-binary and intersex youth, adults, seniors, and families.

(f) Providing grants for educational and vocational training programs developed by, or in consultation with, transgender, gender nonconforming, non-binary and intersex individuals to increase the employment status and educational attainment level of transgender, gender nonconforming, non-binary and intersex residents of New York state.

(g) Providing funds to improve data collection on gender identity and expression in New York state with a focus on transgender, gender nonconforming, non-binary and intersex residents of New York state and their needs.

TITLE III

STATE HEALTH AREAS

Section 240. State health areas; establishment; regional and district; appointment of officers.

241. Regional health directors; powers and duties.

242. District health officers; powers and duties.

243. State health areas; professional and other employees.

*** § 240. State health areas; establishment; regional and district; appointment of officers.** 1. The commissioner shall from time to time divide the state, except cities of the first class, into as many regional and district health areas as he may determine to be necessary for the efficient operation of the department.

2. The commissioner shall appoint for each regional health area a regional health director who shall be a physician.

3. The commissioner shall appoint for each district health area a state district health officer who shall be a physician licensed or eligible for license to practice medicine and surgery in this state.

* NB There are 2 § 240's

*** § 241. Regional health directors; powers and duties.** Each regional health director, subject to the provisions of this chapter and the sanitary code, shall act as the representative of the commissioner in all matters affecting public health within his region and shall perform such duties and exercise such powers as may be assigned to him by the commissioner.

* NB There are 2 § 241's

*** § 242. District health officers; powers and duties.** 1. Each state district health officer, under the direction of the commissioner and subject to the provisions of this chapter and the sanitary code, shall act under the immediate supervision of the regional health director of the regional health area in which his district is located, as the representative of the commissioner in all matters affecting public health within his district, and shall perform such duties and exercise such powers as may be assigned to him.

2. Each state district health officer shall act as the representative of the commissioner, and under his direction, in securing the enforcement within his district of the provisions of the public health law and the sanitary code.

* NB There are 2 § 242's

*** § 243. State health areas; professional and other employees.**

Whenever he may deem it expedient so to do, the commissioner may employ such professional or other assistants or employees as he shall consider necessary within the limits of his appropriation, and may assign them from time to time to regional and district health areas and in such manner as in his judgment will best aid in the control of communicable diseases and in the promotion of public health.

* NB There are 2 § 243's

TITLE IV

SPINAL CORD INJURY RESEARCH BOARD

Section 250. Spinal cord injury research board.

251. Powers and duties.

§ 250. Spinal cord injury research board. 1. A spinal cord injury research board is hereby created within the department for the purpose of administering spinal cord injury research projects and administering the spinal cord injury research trust fund created pursuant to section ninety-nine-f of the state finance law. The purpose of research projects administered by the board shall be neurological research towards a cure for such injuries and their effects. The members of the spinal cord injury research board shall include but not be limited to representatives of the following fields: neuroscience, neurology, neuro-surgery, neuro-pharmacology, and spinal cord rehabilitative medicine. The board shall be composed of thirteen members, seven of whom shall be appointed by the governor, two of whom shall be appointed by the temporary president of the senate, two of whom shall be appointed by the speaker of the assembly, one of whom shall be appointed by the minority leader of the senate, and one of whom shall be appointed by the minority leader of the assembly.

2. Board members shall be reimbursed for ordinary travel expenses,

including meals and lodging, incurred in the performance of duties pursuant to section two hundred fifty-one of this title.

3. The terms of board members shall be four years commencing January first, nineteen hundred ninety-nine.

4. At the end of a term, a member shall continue to serve until a successor is appointed. A member who is appointed after a term has begun shall serve the rest of the term and until a successor is appointed. A member who serves two consecutive full four year terms shall not be eligible for reappointment for four years after completion of those terms.

5. A majority of the full authorized membership of the board shall constitute a quorum.

6. One member of the board shall be chosen by the governor to serve as chairperson.

7. Meetings of the board shall be held at least twice a year but may be held more frequently as deemed necessary, subject to call by the chairman or by request of a majority of the board members. Board meetings shall concern, among other things, policy matters relating to spinal cord injury research projects and programs, research progress reports, and other matters necessary to carry out the intent of this title.

8. Members of the board shall be indemnified pursuant to section seventeen of the public officers law.

§ 251. Powers and duties. The spinal cord injury research board created pursuant to section two hundred fifty of this title shall:

1. Formulate policies and procedures necessary to carry out the provisions of this title;

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

3. Ensure that state funds, appropriated for spinal cord injury research are not diverted to any other use; and

4. Provide the governor and the legislature an annual report by January thirty-first of each year succeeding the year in which this title shall take effect setting forth the status of funds appropriated for spinal cord injury research and the progress of the board in terms of the results of its spinal cord injury research efforts.

* TITLE V

HEALTH CARE PRACTITIONER VOLUNTEER PILOT PROGRAM

Section 260. Health care practitioner volunteer program.

* NB There are 2 Title 5's

* **§ 260. Health care practitioner volunteer program.** 1. There is hereby established in the department a health care practitioner volunteer program to implement a system by which eligible health care practitioner volunteers and other volunteers may provide free basic primary health care services to uninsured low income individuals.

2. The commissioner is authorized and directed to promulgate such rules and regulations as are necessary to implement the provisions of this title. Such rules and regulations shall enable the health care practitioner volunteer program approved hereunder to:

(a) provide free basic primary health care services primarily to

uninsured low income individuals;

(b) integrate the delivery of such services with the delivery of health care and other supportive services to the target population by other providers in the community; and

(c) meet standards of care which are appropriate to the level and nature of health care services to be provided.

3. A health care practitioner is eligible to participate as a health care practitioner volunteer under this title if he or she:

(a) is licensed, or exempt from licensure, pursuant to articles one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-seven, one hundred thirty-nine, one hundred forty, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four, one hundred fifty-five, one hundred fifty-six, one hundred fifty-seven, one hundred fifty-nine, one hundred sixty, one hundred sixty-two, or one hundred sixty-four of the education law;

(b) has agreed to practice in a health care practitioner volunteer program without compensation or the expectation of compensation. For the purposes of this paragraph, the following shall not be considered compensation: (i) nominal payment solely to enable the health care practitioner to be considered an employee of an entity operating and administering the health care practitioner volunteer program established pursuant to this title; or (ii) the provision of medical liability insurance coverage to the health care practitioner pursuant to the requirements of this title;

(c) is well qualified and intends to serve as a volunteer in the practice or specialty area in which he or she is licensed and primarily practices, or practiced prior to retirement, or is licensed and demonstrably qualified to practice through training, retraining, or continuing education; and

(d) is not subject to any limitations on practice as the result of findings or action by, or any agreement with, any licensing or professional conduct agency or board, or any court or regulatory agency.

4. No health care practitioner volunteer shall participate in the

health care practitioner volunteer program established pursuant to this title unless, with respect to acts and omissions that occurred or allegedly occurred within the scope of his or her participation in such program, he or she is covered by an adequate professional liability insurance policy.

5. The commissioner shall, upon submission of satisfactory evidence of compliance with the provisions of this title, approve one or more health care practitioner volunteer programs to be located in and to serve a specified service area. Such program shall:

(a) be operated and administered by a not-for-profit entity licensed under article twenty-eight of this chapter, provided, however, that nothing contained herein shall preclude a facility otherwise licensed under this chapter or under the mental hygiene law from utilizing the services of health care practitioner volunteers for the provision of free health care services pursuant to such licensure; and

(b) have procedures to screen participating health care practitioner volunteers to ensure that they meet the requirements of subdivision three of this section.

6. (a) Each program shall report annually to the commissioner on the progress of the program. The report shall include a profile of participating health care practitioner volunteers, the number of persons served, a description of the activities of the program, an outline of the program's continuing or projected activities, a description of the impact of the program on the community, and an estimate of the value of volunteer services provided.

(b) On or before June first of each year, the commissioner shall report to the governor, the temporary president of the senate, the minority leader of the senate, the speaker of the assembly, the minority leader of the assembly, and the chairs of the senate and assembly committees on health on findings, conclusions, and recommendations on the implementation of the provisions of this title.

7. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is authorized to waive, modify or suspend the provisions of rules and regulations promulgated pursuant to article

twenty-eight of this chapter if the commissioner determines that such waiver, modification or suspension is necessary for the successful implementing of the health care practitioner volunteer program authorized pursuant to this section and provided that the commissioner determines that the health, safety and general welfare of people receiving health care under such health care practitioner volunteer program will not be impaired as a result of such waiver, modification or suspension.

* NB There are 2 § 260's

* TITLE V

OBESITY PREVENTION ACT

Section 260*2. Short title.

261. Legislative intent.

262. Definitions.

263. Department authorized to study obesity-report.

* NB There are 2 Title 5's

* **§ 260. Short title.** This title shall be known and may be cited as the "obesity prevention act".

* NB There are 2 § 260's

§ 261. Legislative intent. The legislature hereby finds, determines, and declares that obesity is a serious medical problem affecting up to one-third of all Americans. In addition, a nineteen ninety-seven Kaiser Permanente study concluded that there is a significant potential for a reduction in health care expenditures through obesity prevention. In addition:

1. Obesity is known to cause or exacerbate a number of serious disorders including hypertension, dyslipidemia, cardiovascular disease, diabetes, respiratory dysfunction, gout, and osteoarthritis;

2. Nearly eighty percent of patients with diabetes mellitus are obese;

3. Nearly seventy percent of diagnosed cases of cardiovascular disease are related to obesity; and

4. Obesity ranks second only to smoking as a preventable cause of death, with some three hundred thousand deaths annually attributable to obesity.

§ 262. Definitions. As used in this title, unless the context otherwise requires:

"Obesity" means the condition in which a person's body mass index is at least thirty kilograms per meter squared, or where a person's body mass index is at least twenty-seven kilograms per meter squared and the person suffers from one or more of the following conditions or diseases:

1. Type II diabetes;
2. Impaired glucose tolerance;
3. Hyperinsulinemia;
4. Dyslipidemia;
5. Hypertension;
6. Cardiovascular disease;
7. Cerebrovascular disease;
8. Osteoarthritis of the hips or knees;
9. Sleep apnea;
10. Gastric reflux disease; or
11. Gall bladder disease.

§ 263. Department authorized to study obesity - report. 1. The department is authorized to sample and collect data on individual cases where obesity is being actively treated and to analyze such data in order to evaluate the impact of treating obesity. Such data collection and analysis shall include the following:

a. The effectiveness of existing methods for treating or preventing obesity;

b. The effectiveness of alternate methods for treating or preventing obesity;

c. The fiscal impact of treating or preventing obesity;

d. The compliance and cooperation of patients with various methods of treating or preventing obesity; or

e. The reduction in serious medical problems associated with diabetes that results from treating or preventing obesity.

2. The department is authorized to fund the research authorized in subdivision one of this section from gifts, grants, and donations from individuals, private organizations, foundations, or any governmental unit; except that no gift, grant, or donation may be accepted by the department if it is subject to conditions that are inconsistent with this title or any other laws of this state. The department shall have the power to direct the disposition of any such gift, grant, or donation for the purposes of this title.

3. After completion of the research authorized in subdivision one of this section, the department shall submit a report and supporting materials to the governor and the legislature by June first of the following year.

TITLE VI
WOMEN'S HEALTH

- Section 266. Department website.
267. Menstrual products in schools.
- 267-a. Self-administered hormonal contraceptives.
- 267-b. Menstrual products in public colleges and universities.
- 268*2. Informational materials concerning menstrual disorders.

§ 266. Department website. 1. The department shall establish and maintain an internet website for the purpose of advancing women's health initiatives. The website shall provide information for the purposes of educating the public and raising awareness of women's health issues, provide links to useful resources and encourage the use of services now made more widely available to the women of New York state. The website shall also promote the following preventative services now covered pursuant to federal law and regulation, and explain that such services must be covered with no cost sharing:

- (a) Anemia screening for pregnant women;
- (b) Bacteriuria urinary tract or other infection screening for pregnant women;
- (c) BRCA counseling about genetic testing for women at higher risk;
- (d) Breast cancer mammography screenings every one to two years for women over age forty;
- (e) Breast cancer chemoprevention counseling for women at higher risk;
- (f) Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- (g) Cervical cancer screening for sexually active women;
- (h) Chlamydia infection screening for younger women and other women at higher risk;
- (i) Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
- (j) Domestic and interpersonal violence screening and counseling for all women;
- (k) Folic acid supplements for women who may become pregnant;

- (l) Gestational diabetes screening for women twenty-four to twenty-eight weeks pregnant and those at high risk of developing gestational diabetes;
- (m) Gonorrhea screening for all women at higher risk;
- (n) Hepatitis B screening for pregnant women at their first prenatal visit;
- (o) Human immunodeficiency virus (HIV) screening and counseling for sexually active women;
- (p) Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are thirty years of age or older;
- (q) Osteoporosis screening for women over age sixty depending on risk factors;
- (r) RH incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- (s) Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- (t) Sexually transmitted infections (STI) counseling for sexually active women;
- (u) Syphilis screening for all pregnant women or other women at increased risk; and
- (v) Well-woman visits to obtain recommended preventive services.

2. The commissioner shall develop and update as necessary information on possible complications from pregnancy that can endanger the life or health of the newborn or the mother for purposes of advancing women's health initiatives, pursuant to subdivision one of this section. Such information shall be developed in consultation with any state or local government maternal mortality review boards and health care providers or other experts in the field of women and newborn health. Such information shall be posted on the website in a printable format, in each of the top six languages spoken in the state, other than English, according to the latest available data from the United States Census Bureau, to allow all general hospitals, diagnostic and treatment centers, obstetricians, primary care providers, midwives, and other health care programs providing women's wellness services to provide the information to their patients as part of their wellness education or prenatal care

activities.

3. The department shall also consider making use of social media networks for the purposes of advancing such initiatives.

4. Information pursuant to subdivision two of this section shall include information related to pre-term labor and premature birth, including but not limited to definitions and information on the risks of pre-term labor and premature birth to the expectant mother and fetus, as well as signs and symptoms of pre-term labor. The information shall also include:

(a) a statement that the medical assistance program provides coverage for all income-eligible pregnant women residing in the state regardless of immigration status; and

(b) a statement informing individuals of their right to request a hospital discharge review in accordance with section twenty-eight hundred three-i of this article if they believe they are being asked to leave a hospital too soon; and

(c) a statement informing individuals that hospitals must determine whether an expectant mother is experiencing an emergency medical condition, and upon making a diagnosis of an emergency medical condition, admit the expectant mother to the general hospital or treat them in the emergency room for close observation and continuous monitoring until it is deemed medically safe for discharge or transfer in accordance with state and federal requirements including the federal Emergency Medical Treatment and Labor Act (EMTALA).

5. The department shall develop educational materials to be provided to emergency room medical staff regarding the state and federal discharge and transfer requirements.

6. Cytomegalovirus. (a) In addition to information provided pursuant to this section, the commissioner shall also develop comprehensive informational materials, which shall include, but not be limited to, the symptoms, the risks, the transmission and the prevention of cytomegalovirus and the effects that such virus may have on a pregnant individual, an individual who may become pregnant, and children.

(b) i. The commissioner shall distribute such cytomegalovirus informational materials to:

(1) licensed physicians who practice obstetric and/or gynecology in this state; and

(2) those licensed to practice midwifery pursuant to article one hundred forty of the education law.

ii. Such physicians or midwives shall provide the cytomegalovirus informational materials to each pregnant patient during such patient's first appointment with such physician or midwife.

*** § 267. Menstrual products in schools.** All elementary and secondary public schools in the state serving students in any grade from grade six through grade twelve shall provide menstrual products in the restrooms of such school building or buildings. Such products shall be provided at no charge to students.

* NB Effective until July 1, 2024

* § 267. Menstrual products in schools. 1. All elementary and secondary public schools and non-public schools in the state serving students in any grade from grade six through grade twelve shall provide menstrual products in the restrooms of such school building or buildings. Such products shall be provided at no charge to students.

2. A non-public school may be granted an exemption from the requirements of subdivision one of this section upon a demonstration sufficient to the commissioner of education that the school does not serve students who need such products and that menstrual products are available in a manner that ensures the privacy of any student seeking them within the school building or buildings, including but not limited to within any gender-neutral restroom. Such exemption may be revoked should the circumstances change on which the exemption is granted.

* NB Effective July 1, 2024

§ 267-a. Self-administered hormonal contraceptives. The commissioner is authorized to establish a non-patient specific order, consistent with

section sixty-eight hundred one of the education law, for dispensing self-administered hormonal contraceptives as defined in section sixty-eight hundred two of such chapter.

§ 267-b. Menstrual products in public colleges and universities. All public colleges and universities in the state shall provide menstrual products in the restrooms of such school building or buildings. Such products shall be provided at no charge to students.

*** § 268. Informational materials concerning menstrual disorders.** Subject to appropriation, the commissioner, in conjunction with the commissioner of education, shall create age specific informational materials to be provided to school districts and health care practitioners upon request to distribute to students and patients educating them about menstrual disorders and their symptoms. The materials shall include, but be not limited to:

1. the timing, signs and symptoms of endometriosis and other menstrual disorders;
2. the importance of menstrual health and its impacts on one's physical, emotional, social, and academic life;
3. basic statistics on endometriosis and other menstrual disorders;
4. best practices on how to be one's own healthcare advocate; and
5. basic treatment options for endometriosis and other menstrual disorders, as well as recommendations for follow-up care from a healthcare provider.

* NB There are 2 § 268's

TITLE 6-A

THE 21ST CENTURY WORKGROUP FOR DISEASE ELIMINATION AND REDUCTION

Section 266-a. The 21st century workgroup for disease elimination and reduction.

§ 266-a. The 21st century workgroup for disease elimination and reduction. The 21st century workgroup for disease elimination and reduction is hereby created within the department. The workgroup shall:

1. Be comprised of experts within the department's bureau of immunization, experts on the immunization advisory council and other experts the commissioner deems appropriate, charged with the mission of reviewing existing vaccines, the status of international research and development for vaccines likely to be candidates for the pharmaceutical marketplace, and to review the status of health threats which could be addressed by the development of vaccines;

2. Study the severity, frequency of occurrence, likelihood of recurrence, existing animal vaccines and potential human vaccines for tuberculosis, eastern equine encephalitis virus, Lyme disease, human immunodeficiency virus, and any other disease or virus the commissioner deems appropriate;

3. Consult with national vaccine and immunization policy making organizations, including but not limited to, the advisory committee on immunization practices under the centers for disease control and prevention, the national institute of health and the national institute of allergy and infectious diseases;

4. Apply for grants, accept gifts from private and public sources for purposes set forth herein; and

5. Report every three years, commencing January first, two thousand eighteen, to the commissioner, the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on health, and the chair of the assembly health committee.

TITLE VII
NY STATE OF HEALTH

Section 268. Statement of policy and purposes.

268-a. Definitions.

268-b. Establishment of NY State of Health, The Official Health Plan Marketplace.

268-c. Functions of the Marketplace.

268-d. Special functions of the Marketplace related to health plan certification and qualified health plan oversight.

268-e. Appeals and appeal hearings; judicial review.

268-f. Marketplace advisory committee.

268-g. Funding of the Marketplace.

268-h. Construction.

*** § 268. Statement of policy and purposes.** The purpose of this title is to codify the establishment of the health benefit exchange in New York, known as NY State of Health, The Official Health Plan Marketplace (Marketplace), in conformance with Executive Order 42 (Cuomo) issued April 12, 2012. The Marketplace shall continue to perform eligibility determinations for federal and state insurance affordability programs including medical assistance in accordance with section three hundred sixty-six of the social services law, child health plus in accordance with section twenty-five hundred eleven of this chapter, the basic health program in accordance with section three hundred sixty-nine-gg of the social services law, the 1332 state innovation program in accordance with section three hundred sixty-nine-ii of the social service law, and premium tax credits and cost-sharing reductions, together with performing eligibility determinations for qualified health plans and such other health insurance programs as determined by the commissioner. The Marketplace shall also facilitate enrollment in insurance affordability programs, qualified health plans and other health insurance programs as determined by the commissioner, the purchase and sale of qualified health plans and/or other or additional health plans certified by the Marketplace pursuant to this title, and shall continue to have the authority to operate a small business health options program ("SHOP") to assist eligible small employers in selecting qualified

health plans and/or other or additional health plans certified by the Marketplace and to determine small employer eligibility for purposes of small employer tax credits. It is the intent of the legislature, by codifying the Marketplace in state statute, to continue to promote quality and affordable health coverage and care, reduce the number of uninsured persons, provide a transparent marketplace, educate consumers and assist individuals with access to coverage, premium assistance tax credits and cost-sharing reductions. In addition, the legislature declares the intent that the Marketplace continue to be properly integrated with insurance affordability programs, including Medicaid, child health plus and the basic health program, the 1332 state innovation program, and such other health insurance programs as determined by the commissioner.

* NB There are 2 § 268's

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

1. "Commissioner" means the commissioner of health of the state of New York.

2. "Marketplace" means the "NY State of Health, The official health plan Marketplace" or "Marketplace" established as a health benefit exchange or "marketplace" within the department of health pursuant to Executive Order 42 (Cuomo) issued April 12, 2012 and this title.

3. "Federal act" means the patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and any regulations or guidance issued thereunder.

4. "Health plan" means a policy, contract or certificate, offered or issued by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health plan shall not include the following:

(a) accident insurance or disability income insurance, or any

combination thereof;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile no-fault insurance;

(f) credit insurance;

(g) other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(h) limited scope dental or vision benefits, benefits for long-term care insurance, nursing home insurance, home care insurance, or any combination thereof, or such other similar, limited benefits health insurance as specified in federal regulations, if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan;

(i) coverage only for a specified disease or illness, hospital indemnity, or other fixed indemnity coverage;

(j) Medicare supplemental insurance as defined in section 1882(g)(1) of the federal social security act, coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, or similar supplemental coverage provided under a group health plan if it is offered as a separate policy, certificate or contract of insurance; or

(k) the New York state medical indemnity fund established pursuant to title four of article twenty-nine-D of the public health law.

5. "Insurer" means an insurance company subject to article forty-two or a corporation subject to article forty-three of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law that contracts or offers to contract to provide, deliver, arrange, pay or reimburse any of the costs of health care services.

6. "Stand-Alone dental plan" means a dental services plan that has been issued pursuant to applicable law and certified by the Marketplace in accordance with section two hundred sixty-eight-d of this title.

7. "Qualified health plan" means a health plan that is issued pursuant to applicable law and certified by the Marketplace in accordance with section two hundred sixty-eight-d of this title, including a stand-alone dental plan.

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

9. "Eligible individual" means an individual, including a minor, who is eligible to enroll in an insurance affordability program or other health insurance program as determined by the commissioner.

10. "Qualified individual" means, with respect to qualified health plans, an individual, including a minor, who:

(a) is eligible to enroll in a qualified health plan offered to individuals through the Marketplace;

(b) resides in this state;

(c) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(d) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or a noncitizen lawfully present in the United States.

11. "Secretary" means the secretary of the United States department of health and human services.

12. "SHOP" means the small business health options program operated by the Marketplace to assist eligible small employers in this state in selecting qualified health plans and/or other or additional health plans certified by the Marketplace and to determine small employer eligibility for purposes of small employer tax credits in accordance with applicable federal and state laws and regulations.

13. "Small employer" means an employer which offers coverage where the

coverage such employer offers would be considered small group coverage under the insurance law and regulations promulgated thereunder, provided that it is not otherwise prohibited under the federal act.

14. "Small group market" means the health insurance market under which individuals receive health insurance coverage on behalf of themselves and their dependents through a group health plan maintained by a small employer.

15. "Superintendent" means the superintendent of financial services.

16. "Essential health benefits" shall mean the categories of benefits defined in subsection (a) of section three thousand two hundred seventeen-i and subsection (a) of section four thousand three hundred six-h of the insurance law.

§ 268-b. Establishment of NY State of Health, The Official Health Plan Marketplace. 1. There is hereby established an office within the department of health to be known as the "NY State of Health, The official health plan Marketplace".

2. The purpose of the Marketplace is to facilitate enrollment in health coverage and the purchase and sale of qualified health plans and other health plans certified by the Marketplace; enroll individuals in coverage for which they are eligible in accordance with federal and state law; enable eligible individuals to receive premium tax credits, cost-sharing reductions, and to access insurance affordability programs and other health insurance programs as determined by the commissioner; assist eligible small employers in selecting qualified health plans and/or other, or additional health plans certified by the Marketplace and to qualify for small employer tax credits in accordance with applicable law; and to carry out other functions set forth in this title.

§ 268-c. Functions of the Marketplace. The Marketplace shall:

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

(b) certify and make available to qualified individuals, qualified health plans, including dental plans, certified by the Marketplace pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace; and

(c) certify and/or make available to eligible individuals, health plans certified by the Marketplace pursuant to applicable law, and/or participating in an insurance affordability program pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace, and/or approval by the commissioner.

2. Assign an actuarial value to each Marketplace certified plan offered through the Marketplace in accordance with the criteria developed by the secretary pursuant to federal law or the superintendent pursuant to the insurance law and/or requirements developed by the Marketplace, and determine each health plan's level of coverage in accordance with regulations issued by the secretary pursuant to federal law or the superintendent pursuant to the insurance law.

3. Utilize a standardized format for presenting health benefit options in the Marketplace, including the use of the uniform outline of coverage established under section 2715 of the federal public health service act or the insurance law.

4. Standardize the benefits available through the Marketplace at each level of coverage defined by the superintendent in the insurance law.

5. Maintain enrollment periods in the best interest of qualified individuals consistent with federal and state law.

6. Implement procedures for the certification, recertification and decertification of health plans as qualified health plans or health plans approved for sale by the department of financial services or department of health and certified by the Marketplace, consistent with guidelines developed by the secretary pursuant to section 1311(c) of the federal act and requirements developed by the Marketplace.

7. Contract for health care coverage offered to qualified individuals through the Marketplace, and in doing so shall seek to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

8. Contract for health care coverage offered to certain eligible individuals through the Marketplace, pursuant to health insurance programs as determined by the commissioner, and in doing so shall seek to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service;

9. Provide the minimum requirements an insurer shall meet to participate in the Marketplace, in the best interest of qualified individuals or eligible individuals;

10. Require qualified health plans and/or other health plans certified by the Marketplace to offer those benefits determined to be essential health benefits pursuant to state law or as required by the Marketplace.

11. Ensure that insurers offering health plans through the Marketplace do not charge an individual enrollee a fee or penalty for termination of coverage.

12. Provide for the operation of a toll-free telephone hotline to

respond to requests for assistance.

13. Maintain an internet website through which enrollees and prospective enrollees of qualified health plans and health plans certified by the Marketplace may obtain standardized comparative information on such plans and insurance affordability programs.

14. Make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 or applicable state law and any cost-sharing reduction under federal or applicable state law.

15. Operate a program under which the Marketplace awards grants to entities to serve as navigators in accordance with applicable federal law and regulations adopted thereunder, and/or a program under which the Marketplace awards grants to entities to provide community based enrollment assistance in accordance with requirements developed by the Marketplace; and/or a program under which the Marketplace certifies New York state licensed producers to provide assistance to eligible individuals and/or small employers pursuant to federal or state law.

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

17. Grant a certification that an individual is exempt from the requirement to maintain minimum essential coverage pursuant to federal

or state law and from any penalties imposed by such requirements because:

(a) there is no affordable health plan available covering the individual, as defined by applicable law; or

(b) the individual meets the requirements for any other such exemption from the requirement to maintain minimum essential coverage or to pay the penalty pursuant to applicable federal or state law.

18. Operate a small business health options program ("SHOP") pursuant to section 1311 of the federal act and applicable state law, through which eligible small employers may select marketplace-certified qualified health plans offered in the small group market, and through which eligible small employers may receive assistance in qualifying for small business tax credits available pursuant to federal and state law.

19. Enter into agreements as necessary with federal and state agencies and other state Marketplaces to carry out its responsibilities under this title, provided such agreements include adequate protections with respect to the confidentiality of any information to be shared and comply with all state and federal laws and regulations.

20. Perform duties required by the secretary, the secretary of the United States department of the treasury or the commissioner related to determining eligibility for premium tax credits or reduced cost-sharing under applicable federal or state law.

21. Meet program integrity requirements under applicable law, including keeping an accurate accounting of receipts and expenditures and providing reports to the secretary regarding Marketplace related activities in accordance with applicable law.

22. Submit information provided by Marketplace applicants for verification as required by section 1411(c) of the federal act and applicable state law.

23. Establish rules and regulations that do not conflict with or prevent the application of regulations promulgated by the secretary.

24. Determine eligibility, provide notices, and provide opportunities for appeal and redetermination in accordance with the requirements of federal and state law.

25. The commissioner is authorized to submit the appropriate waiver applications to the United States secretary of health and human services and/or the department of the treasury to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148 as amended, or successor provisions, as provided for by 42 U.S.C. 18052, and any other waivers necessary to achieve the purposes of high quality, affordable coverage through NY State of Health, the official health plan marketplace. The commissioner shall implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the secretary of health and human services and/or the secretary of the treasury pursuant to 42 U.S.C. 18052. Copies of such original waiver applications and amendments thereto shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee and the chairs of the senate and assembly health committees simultaneously with their submission to the federal government.

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

* NB Effective upon the commissioner of health obtaining and maintaining certain approvals (see chapter 57 of 2024 Pt. J § 10)

§ 268-d. Special functions of the Marketplace related to health plan certification and qualified health plan oversight. 1. Health plans certified by the Marketplace shall meet the following requirements:

(a) The insurer offering the health plan:

(i) is licensed or certified by the superintendent or commissioner, in good standing to offer health insurance coverage in this state, and meets the requirements established by the Marketplace;

(ii) offers at least one qualified health plan and/or other or additional health plans authorized for sale by the department of financial services or the department in each of the silver and gold levels as required by state law, provided, however, that the Marketplace may require additional benefit levels to be offered by all insurers participating in the Marketplace;

(iii) has filed with and received approval from the superintendent of its premium rates and policy or contract forms pursuant to the insurance law and/or this chapter;

(iv) does not charge any cancellation fees or penalties for termination of coverage in violation of applicable law; and

(v) complies with the regulations developed by the secretary under section 1311(c) of the federal act and such other requirements as the Marketplace may establish.

(b) The health plan: (i) provides the essential health benefits package described in state law or required by the Marketplace and includes such additional benefits as are mandated by state law, except that the health plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans if:

(A) the Marketplace has determined that at least one qualified dental plan or dental plan approved by the department of financial services or the department is available to supplement the health plan's coverage; and

(B) the insurer makes prominent disclosure at the time it offers the health plan, in a form approved by the Marketplace, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans or dental plans approved by the department of financial services or department of health providing those benefits and other dental benefits not covered by the plan are offered through the Marketplace;

(ii) provides at least a bronze level of coverage as defined by state law, unless the plan is certified as a qualified catastrophic plan, as defined in section 1302(e) of the federal act and the insurance law, and

shall only be offered to individuals eligible for catastrophic coverage;

(iii) has cost-sharing requirements, including deductibles, which do not exceed the limits established under section 1302(c) of the federal act, state law and any requirements of the Marketplace;

(iv) complies with regulations promulgated by the secretary pursuant to section 1311(c) of the federal act and applicable state law, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance;

* (v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements;

* NB Effective until January 1, 2028

* (v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; and

* NB Effective January 1, 2028

* (vi) contracts with any national cancer institute-designated cancer center licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to enrollees in all health plans offering coverage through the Marketplace in such cancer center's service area under the prevailing terms and conditions that the plan requires of other similar providers to be included in the plan's provider network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; and

* NB Effective until January 1, 2028

* (vi) complies with the insurance law and this chapter requirements applicable to health insurance issued in this state and any regulations promulgated pursuant thereto that do not conflict with or prevent the application of federal requirements; and

* NB Effective January 1, 2028

* (vii) complies with the insurance law and this chapter requirements applicable to health insurance issued in this state and any regulations

promulgated pursuant thereto that do not conflict with or prevent the application of federal requirements; and

* NB Repealed January 1, 2028

(c) The Marketplace determines that making the health plan available through the Marketplace is in the interest of qualified individuals in this state.

2. The Marketplace shall not exclude a health plan:

(a) on the basis that the health plan is a fee-for-service plan;

(b) through the imposition of premium price controls by the Marketplace; or

(c) on the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Marketplace determines are inappropriate or too costly.

3. The Marketplace shall require each insurer certified or seeking certification of a health plan as a qualified health plan or plan approved for sale by the department of financial services or the department to:

(a) submit a justification for any premium increase pursuant to applicable law prior to implementation of such increase. The insurer shall prominently post the information on its internet website. Such rate increases shall be subject to the prior approval of the superintendent pursuant to the insurance law;

(b)(i) make available to the public and submit to the Marketplace, the secretary and the superintendent, accurate and timely disclosure of:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment and disenrollment;

(D) data on the number of claims that are denied;

(E) data on rating practices;

(F) information on cost-sharing and payments with respect to any out-of-network coverage;

(G) information on enrollee and participant rights under title I of the federal act; and

(H) other information as determined appropriate by the secretary or otherwise required by the Marketplace;

(ii) the information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the federal act and state law, and in guidance jointly issued thereunder by the secretary and the federal secretary of labor; and

(c) provide to individuals, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an internet website and through other means for individuals without access to the internet.

4. The Marketplace shall not exempt any insurer seeking certification of a health plan, regardless of the type or size of the insurer, from licensing or solvency requirements under the insurance law or this chapter, and shall apply the criteria of this section in a manner that ensures a level playing field for insurers participating in the Marketplace.

5. (a) The provisions of this article that apply to qualified health plans and plans approved for sale by the department of financial services and the department also shall apply to the extent relevant to qualified dental plans approved for sale by the department of financial services or the department, except as modified in accordance with the provisions of paragraphs (b) and (c) of this subdivision or otherwise required by the Marketplace.

(b) The qualified dental plan or dental plan approved for sale by the department of financial services and/or the department shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the Marketplace or secretary may specify in regulations.

(c) Insurers may jointly offer a comprehensive plan through the Marketplace in which an insurer provides the dental benefits through a

qualified dental plan or plan approved by the department of financial services or the department and an insurer provides the other benefits through a qualified health plan, provided that the plans are priced separately and also are made available for purchase separately at the same price.

§ 268-e. Appeals and appeal hearings; judicial review. 1. Any applicant or enrollee, or any individual authorized to act on behalf of any such applicant or enrollee, may appeal to the department from determinations of department officials or failures to make determinations upon grounds specified in subdivision four of this section. The department must review the appeal de novo and give such person an opportunity for an appeal hearing. The department may also, on its own motion, review any decision made or any case in which a decision has not been made by the Marketplace or a social services official within the time specified by law or regulations of the department. The department may make such additional investigation as it may deem necessary, and the commissioner must make such determination as is justified and in accordance with applicable law.

2. Regarding any appeal pursuant to this section, with or without an appeal hearing, the commissioner may designate and authorize one or more appropriate members of his staff to consider and decide such appeals. Any staff member so designated and authorized will have authority to decide such appeals on behalf of the commissioner with the same force and effect as if the commissioner had made the decisions. Appeal hearings must be held on behalf of the commissioner by members of his staff who are employed for such purposes or who have been designated and authorized by the commissioner.

3. Persons entitled to appeal to the department pursuant to this section must include:

(a) applicants for or enrollees in insurance affordability programs and qualified health plans; and

(b) other persons entitled to an opportunity for an appeal hearing as directed by the commissioner.

4. An applicant or enrollee has the right to appeal at least the following issues:

(a) An eligibility determination made in accordance with this article and applicable law, including:

(i) An initial determination of eligibility, including:

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

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

(E) eligibility for the 1332 state innovation program;

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

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

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

(ii) a re-determination of eligibility of the programs under this subdivision.

(b) An eligibility determination for an exemption for any mandate to purchase health insurance.

(c) A failure by NY State of Health to provide timely written notice of an eligibility determination made in accordance with applicable law.

5. The department may, subject to the discretion of the commissioner, promulgate such regulations, consistent with federal or state law, as may be necessary to implement the provisions of this section.

6. Regarding every decision of an appeal pursuant to this section, the department must inform every party, and his or her representative, if any, of the availability of judicial review and the time limitation to pursue future review.

7. Applicants and enrollees of qualified health plans, with or without advance payments of the premium tax credit and cost-sharing reductions, also have the right to appeal to the United States Department of Health and Human Services appeal entity:

(a) appeals decisions issued by NY State of Health upon the exhaustion of the NY State of Health appeals process; and

(b) a denial of a request to vacate a dismissal made by the NY State of Health appeals entity.

8. The department must include notice of the right to appeal as provided by subdivision four of this section and instructions regarding how to file an appeal in any eligibility determination issued to the applicant or enrollee in accordance with applicable law. Such notice shall include:

(a) an explanation of the applicant or enrollee's appeal rights;

(b) a description of the procedures by which the applicant or enrollee may request an appeal;

(c) information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

(d) an explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision; and

(e) an explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change will be handled as a redetermination of eligibility for all household members in accordance with the standards specified in applicable law.

§ 268-f. Marketplace advisory committee. 1. There is hereby created the marketplace advisory committee, which shall consider and advise the department and commissioner on matters concerning the provision of health care coverage through the NY State of Health or Health Plan Marketplace.

2. The marketplace advisory committee shall be composed of up to twenty-eight members consisting of twenty-four members appointed by the commissioner, two members appointed by the speaker of the assembly, and two members appointed by the temporary president of the senate. The advisory committee shall at all times be representative of each

geographic area of the state and include:

(a) representatives from the following categories, but not more than six from any single category:

- (i) health plan consumer advocates;
- (ii) small business consumer representatives;
- (iii) health care provider representatives;
- (iv) representatives of the health insurance industry;

(b) representatives from the following categories, but not more than two from either category:

- (i) licensed insurance producers; and
- (ii) representatives of labor organizations.

3. The commissioner shall select the chair of the advisory committee from among the members of such committee and shall designate an officer or employee of the department to assist the marketplace advisory committee in the performance of its duties under this section. The Marketplace shall adopt rules for the governance of the advisory committee, which shall meet as frequently as its business may require and at such other times as determined by the chair to be necessary, in consultation with the executive director of the Marketplace.

4. Members of the advisory committee shall serve without compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

§ 268-g. Funding of the Marketplace. 1. The Marketplace shall be funded by state and federal sources as authorized by applicable law, including but not limited to applicable law authorizing the respective insurance affordability programs available through the Marketplace.

2. The accounts of the Marketplace shall be subject to supervision of the comptroller and such accounts shall include receipts, expenditures, contracts and other matters which pertain to the fiscal soundness of the Marketplace.

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, upon request of the director of the budget, in consultation with the commissioner, the superintendent and the executive director of the Marketplace, the comptroller is hereby authorized and directed to sub-allocate or transfer special revenue federal funds appropriated to the department for planning and implementing various healthcare and insurance reform initiatives authorized by applicable law. Marketplace moneys sub-allocated or transferred pursuant to this section shall be paid out of the fund upon audit and warrant of the state comptroller on vouchers certified or approved by the Marketplace.

§ 268-h. Construction. Nothing in this article, and no action taken by the Marketplace pursuant hereto, shall be construed to:

1. preempt or supersede the authority of the superintendent or the commissioner; or

2. exempt insurers, insurance producers or qualified health plans from this chapter or the insurance law and any regulations promulgated thereunder.

TITLE 8

HUNGER PREVENTION AND NUTRITION ASSISTANCE PROGRAM

Section 269. Hunger prevention and nutrition assistance program.

§ 269. Hunger prevention and nutrition assistance program. 1. The commissioner shall annually assess changing economic indicators impacting service levels within the hunger prevention nutrition assistance program in all regions of the state. Such assessment may include, but not be limited to, the average cost per meal, personnel costs, transportation costs, fuel costs and storage capacity. The commissioner shall provide a summary of findings to the governor and the legislature to inform funding levels for the hunger prevention and

nutrition assistance program on or before the first day of December each year.

2. On or before the first day of December each year, the commissioner shall review and report to the governor and the legislature on the unmet need for cold storage equipment among regional food banks, food pantries and other emergency food organizations.

ARTICLE 2-A

PRESCRIPTION DRUGS

Title I. Preferred drug and clinical drug review programs (§§ 270-277).

II. Prescription drugs; various provisions (§§ 278--280-d).

III. Prescription forms, electronic prescribing and language assistance (§ 281).

TITLE I

PREFERRED DRUG AND CLINICAL DRUG REVIEW PROGRAMS

Section 270. Definitions.

272. Preferred drug program.

273. Preferred drug program prior authorization.

274. Clinical drug review program.

275. Applicability of prior authorization to EPIC.

276. Education and outreach.

277. Review and reports.

§ 270. Definitions. As used in this article, unless the context clearly requires otherwise:

1. "Administrator" means an entity with which the commissioner contracts for the purpose of administering elements of the preferred drug program, as established under section two hundred seventy-two of this article or the clinical drug review program established under section two hundred seventy-four of this article.

2. "Board" shall mean the drug utilization review board.

3. "Clinical drug review program" means the clinical drug review program created by section two hundred seventy-four of this article.

4. "Emergency condition" means a medical or behavioral condition as determined by the prescriber or pharmacists, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, and for which delay in beginning treatment prescribed by the patient's health care practitioner would result in:

- (a) placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;
- (b) serious impairment to such person's bodily functions;
- (c) serious dysfunction of any bodily organ or part of such person;
- (d) serious disfigurement of such person; or
- (e) severe discomfort.

5. "Non preferred drug" means a prescription drug that is included in the preferred drug program and is not one of the drugs on the preferred drug list because it is either: (a) in a therapeutic class that is included in the preferred drug program and is not one of the drugs on the preferred drug list in that class or (b) manufactured by a pharmaceutical manufacturer with whom the commissioner is negotiating or has negotiated a manufacturer agreement and is not a preferred drug under a manufacturer agreement.

6. "Panel" means the elderly pharmaceutical insurance coverage panel established pursuant to section two hundred forty-four of the elder law.

7. "Preferred drug" means a prescription drug that is either (a) in a therapeutic class that is included in the preferred drug program and is one of the drugs on the preferred drug list in that class or (b) a preferred drug under a manufacturer agreement.

8. "Preferred drug program" means the preferred drug program established under section two hundred seventy-two of this article.

9. "Prescription drug" or "drug" means a drug defined in subdivision seven of section sixty-eight hundred two of the education law, for which a prescription is required under the federal food, drug and cosmetic act. Any drug that does not require a prescription under such act, but which would otherwise meet the criteria under this article for inclusion on the preferred drug list may be added to the preferred drug list under this article; and, if so included, shall be considered to be a prescription drug for purposes of this article; provided that it shall be eligible for reimbursement under a state public health plan when ordered by a prescriber authorized to prescribe under the state public health plan and the prescription is subject to the applicable provisions of this article and paragraph (a) of subdivision four of section three hundred sixty-five-a of the social services law.

10. "Prior authorization" means a process requiring the prescriber or the dispenser to verify with the applicable state public health plan or its authorized agent that the drug is appropriate for the needs of the specific patient.

11. "State public health plan" means the medical assistance program established by title eleven of article five of the social services law (referred to in this article as "Medicaid"), the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC"), and the family health plus program established by section three hundred sixty-nine-ee of the social services law to the extent that section provides that the program shall be subject to this article.

12. "Supplemental rebate" means a supplemental rebate under subdivision eleven of section two hundred seventy-two of this article.

13. "Therapeutic class" means a group of prescription drugs that produce a particular intended clinical outcome and are grouped together as a therapeutic class by the pharmacy and therapeutics committee.

14. "Manufacturer agreement" means an agreement between the

commissioner and a pharmaceutical manufacturer under paragraph (b) of subdivision eleven of section two hundred seventy-two of this article.

§ 272. Preferred drug program. 1. There is hereby established a preferred drug program to promote access to the most effective prescription drugs while reducing the cost of prescription drugs for persons in state public health plans.

2. When a prescriber prescribes a non-preferred drug, state public health plan reimbursement shall be denied unless prior authorization is obtained, unless no prior authorization is required under this article.

3. The commissioner shall establish performance standards for the program that, at a minimum, ensure that the preferred drug program and the clinical drug review program provide sufficient technical support and timely responses to consumers, prescribers and pharmacists.

4. Notwithstanding any other provision of law to the contrary, no preferred drug program or prior authorization requirement for prescription drugs, except as created by this article, paragraph (a-1) or (a-2) of subdivision four of section three hundred sixty-five-a of the social services law, paragraph (g) of subdivision two of section three hundred sixty-five-a of the social services law, subdivision one of section two hundred forty-one of the elder law and shall apply to the state public health plans.

5. The drug utilization review board shall consider and make recommendations to the commissioner for the adoption of a preferred drug program. (a) In developing the preferred drug program, the board shall, without limitation: (i) identify therapeutic classes or drugs to be included in the preferred drug program; (ii) identify preferred drugs in each of the chosen therapeutic classes; (iii) evaluate the clinical effectiveness and safety of drugs considering the latest peer-reviewed research and may consider studies submitted to the federal food and drug administration in connection with its drug approval system; (iv) consider the potential impact on patient care and the potential fiscal

impact that may result from making such a therapeutic class subject to prior authorization; and (v) consider the potential impact of the preferred drug program on the health of special populations such as children, the elderly, the chronically ill, persons with HIV/AIDS and persons with mental health conditions.

(b) In developing the preferred drug program, the board may consider preferred drug programs or evidence based research operated or conducted by or for other state governments, the federal government, or multi-state coalitions. Notwithstanding any inconsistent provision of section one hundred twelve or article eleven of the state finance law or section one hundred forty-two of the economic development law or any other law, the department may enter into contractual agreements with the Oregon Health and Science University Drug Effectiveness Review Project to provide technical and clinical support to the board and the department in researching and recommending drugs to be placed on the preferred drug list.

(c) The board shall from time to time review all therapeutic classes included in the preferred drug program, and may recommend that the commissioner add or delete drugs or classes of drugs to or from the preferred drug program, subject to this subdivision.

(d) The board shall establish procedures to promptly review prescription drugs newly approved by the federal food and drug administration.

6. The board shall recommend a procedure and criteria for the approval of non-preferred drugs as part of the prior authorization process. In developing these criteria, the board shall include consideration of the following:

(a) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(b) the patient has tried the preferred drug and has experienced unacceptable side effects;

(c) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; and

(d) other clinical indications for the use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, the elderly, the chronically ill,

persons with mental health conditions, and persons affected by HIV/AIDS.

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

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

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

the commissioner's determination.

10. The commissioner shall adopt a preferred drug program and amendments after considering the recommendations from the board and any comments received from prescribers, dispensers, patients, consumers and manufacturers of the drug.

(a) The preferred drug list in any therapeutic class included in the preferred drug program shall be developed based initially on an evaluation of the clinical effectiveness, safety and patient outcomes, followed by consideration of the cost-effectiveness of the drugs.

(b) In each therapeutic class included in the preferred drug program, the board shall determine whether there is one drug which is significantly more clinically effective and safe, and that drug shall be included on the preferred drug list without consideration of cost. If, among two or more drugs in a therapeutic class, the difference in clinical effectiveness and safety is not clinically significant, then cost effectiveness (including price and supplemental rebates) may also be considered in determining which drug or drugs shall be included on the preferred drug list.

(c) In addition to drugs selected under paragraph (b) of this subdivision, any prescription drug in the therapeutic class, whose cost to the state public health plans (including net price and supplemental rebates) is equal to or less than the cost of another drug in the therapeutic class that is on the preferred drug list under paragraph (b) of this subdivision, may be selected to be on the preferred drug list, based on clinical effectiveness, safety and cost-effectiveness.

(d) Notwithstanding any provision of this section to the contrary, the commissioner may designate therapeutic classes of drugs, including classes with only one drug, as all preferred prior to any review that may be conducted by the board pursuant to this section.

11. (a) The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public health plans for drugs within a therapeutic class; such supplemental rebates shall be taken into consideration by the board and the commissioner in determining the cost-effectiveness of drugs within a therapeutic class under the state public health plans.

(b) The commissioner may designate a pharmaceutical manufacturer as one with whom the commissioner is negotiating or has negotiated a manufacturer agreement, and all of the drugs it manufactures or markets shall be included in the preferred drug program. The commissioner may negotiate directly with a pharmaceutical manufacturer for rebates relating to any or all of the drugs it manufactures or markets. A manufacturer agreement shall designate any or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as being preferred or non preferred drugs. When a pharmaceutical manufacturer has been designated by the commissioner under this paragraph but the commissioner has not reached a manufacturer agreement with the pharmaceutical manufacturer, then the commissioner may designate some or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as non preferred drugs. However, notwithstanding this paragraph, any drug that is selected to be on the preferred drug list under paragraph (b) of subdivision ten of this section on grounds that it is significantly more clinically effective and safer than other drugs in its therapeutic class shall be a preferred drug.

(c) Supplemental rebates under this subdivision shall be in addition to those required by applicable federal law and subdivision seven of section three hundred sixty-seven-a of the social services law. In order to be considered in connection with the preferred drug program, such supplemental rebates shall apply to the drug products dispensed under the Medicaid program and the EPIC program. The commissioner is prohibited from approving alternative rebate demonstrations, value added programs or guaranteed savings from other program benefits as a substitution for supplemental rebates.

13. The commissioner may implement all or a portion of the preferred drug program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

14. For a period of eighteen months, commencing with the date of enactment of this article, and without regard to the preferred drug program or the clinical drug review program requirements of this article, the commissioner is authorized to implement, or continue, a prior authorization requirement for a drug which may not be dispensed

without a prescription as required by section sixty-eight hundred ten of the education law, for which there is a non-prescription version within the same drug class, or for which there is a comparable non-prescription version of the same drug. Any such prior authorization requirement shall be implemented in a manner that is consistent with the process employed by the commissioner for such authorizations as of one day prior to the date of enactment of this article. At the conclusion of the eighteen month period, any such drug or drug class shall be subject to the preferred drug program requirements of this article; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions five through eleven of this section.

§ 273. Preferred drug program prior authorization. 1. For the purposes of this article, a prescription drug shall be considered to be not on the preferred drug list if it is a non preferred drug.

2. The preferred drug program shall make available a twenty-four hour per day, seven days per week telephone call center that includes a toll-free telephone line and dedicated facsimile line to respond to requests for prior authorization. The call center shall include qualified health care professionals who shall be available to consult with prescribers concerning prescription drugs that are not on the preferred drug list. A prescriber seeking prior authorization shall consult with the program call line to reasonably present his or her justification for the prescription and give the program's qualified health care professional a reasonable opportunity to respond.

3. (a) When a patient's health care provider prescribes a prescription drug that is not on the preferred drug list or the statewide formulary of opioid dependence agents and opioid antagonists established pursuant to subparagraph (vii) of paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the prescriber shall consult with the program to confirm that in his or her reasonable professional judgment, the patient's clinical condition is consistent with the criteria for approval of the non-preferred drug. Such criteria

shall include:

(i) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(ii) the patient has tried the preferred drug and has experienced unacceptable side effects;

(iii) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; or

(iv) other clinical indications identified by the drug utilization review board established pursuant to section three hundred sixty-nine-bb of the social services law, which shall include consideration of the medical needs of special populations, including children, elderly, chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS, pregnant persons, and persons with an opioid use disorder.

(a-1) When a patient's health care provider prescribes a prescription drug that is on the statewide formulary of opioid dependence agents and opioid antagonists established pursuant to subparagraph (vii) of paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the department shall not require prior authorization unless required by the department's drug use review program established pursuant to section 1927(g) of the Social Security Act.

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.

(c) If a prescriber meets the requirements of paragraph (a) or (b) of this subdivision, the prescriber shall be granted prior authorization under this section.

(d) In the instance where a prior authorization determination is not completed within twenty-four hours of the original request, solely as

the result of a failure of the program (whether by action or inaction), prior authorization shall be immediately and automatically granted with no further action by the prescriber and the prescriber shall be notified of this determination. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request for any other reason, a seventy-two hour supply of the medication shall be approved by the program and the prescriber shall be notified of this determination.

4. When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, and the prescriber or pharmacist notifies the program that an emergency condition exists, a seventy-two hour emergency supply of the drug prescribed shall be immediately authorized by the program.

5. In the event that a patient presents a prescription to a pharmacist for a prescription drug that is not on the preferred drug list and for which the prescriber has not obtained a prior authorization, the pharmacist shall, within a prompt period based on professional judgment, notify the prescriber. The prescriber shall, within a prompt period based on professional judgment, either seek prior authorization or shall contact the pharmacist and amend or cancel the prescription. The pharmacist shall, within a prompt period based on professional judgment, notify the patient when prior authorization has been obtained or denied or when the prescription has been amended or cancelled.

6. Once prior authorization of a prescription for a drug that is not on the preferred drug list is obtained, prior authorization shall not be required for any refill of the prescription.

7. No prior authorization under the preferred drug program shall be required when a prescriber prescribes a drug on the preferred drug list; provided, however, that the commissioner may identify such a drug for which prior authorization is required pursuant to the provisions of the clinical drug review program established under section two hundred seventy-four of this article.

8. The department shall monitor the prior authorization process for prescribing patterns which are suspected of endangering the health and safety of the patient or which demonstrate a likelihood of fraud or abuse. The department shall take any and all actions otherwise permitted by law to investigate such prescribing patterns, to take remedial action and to enforce applicable federal and state laws.

9. No prior authorization under the preferred drug program shall be required for any prescription under EPIC until the panel has made prior authorization applicable to EPIC under section two hundred seventy-five of this article.

10. Prior authorization shall not be required for any buprenorphine products, methadone, or long acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder.

§ 274. Clinical drug review program. 1. In addition to the preferred drug program established by this article, the commissioner may establish a clinical drug review program. The commissioner may, from time to time, require prior authorization under such program for prescription drugs or patterns of utilization under state public health plans. When a prescriber prescribes a drug which requires prior authorization under this section, state public health plan reimbursement shall be denied unless such prior authorization is obtained.

2. The clinical drug review program shall make available a twenty-four hour per day, seven days per week response system.

3. In establishing a prior authorization requirement for a drug under the clinical drug review program, the commissioner shall consider the following:

(a) whether the drug requires monitoring of prescribing protocols to protect both the long-term efficacy of the drug and the public health;

(b) the potential for, or a history of, overuse, abuse, drug diversion

or illegal utilization; and

(c) the potential for, or a history of, utilization inconsistent with approved indications. Where the commissioner finds that a drug meets at least one of these criteria, in determining whether to make the drug subject to prior authorization under the clinical drug review program, the commissioner shall consider whether similarly effective alternatives are available for the same disease state and the effect of that availability or lack of availability.

4. The commissioner shall obtain an evaluation of the factors set forth in subdivision three of this section and a recommendation as to the establishment of a prior authorization requirement for a drug under the clinical drug review program from the drug utilization review board. For this purpose, the commissioner and the board, as applicable, shall comply with the following meeting and notice processes established by this article:

(a) the open meetings law and freedom of information law provisions of subdivision six of section two hundred seventy-one of this article; and

(b) the public notice and interested party provisions of subdivisions seven, eight and nine of section two hundred seventy-two of this article.

5. The board shall recommend a procedure and criteria for the approval of drugs subject to prior authorization under the clinical drug review program. Such criteria shall include the specific approved clinical indications for use of the drug.

6. The commissioner shall identify a drug for which prior authorization is required, as well as the procedures and criteria for approval of use of the drug, under the clinical drug review program after considering the recommendations from the board and any comments received from prescribers, dispensers, consumers and manufacturers of the drug. In no event shall the prior authorization criteria for approval pursuant to this subdivision result in denial of the prior authorization request based on the relative cost of the drug subject to prior authorization.

7. In the event that the patient does not meet the criteria for approval established by the commissioner in subdivision six of this section, the clinical drug review program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification for prior authorization. If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of the prescription drug is warranted, the prescriber's determination shall be final and prior authorization shall be granted under this section; provided, however, that prior authorization may be denied in cases where the department has substantial evidence that the prescriber or patient is engaged in fraud or abuse relating to the drug.

8. In the event that a patient presents a prescription to a pharmacist for a prescription drug that requires prior authorization under this section and for which prior authorization has not been obtained, the pharmacist shall, within a prompt period based on professional judgment, notify the prescriber. The prescriber shall, within a prompt period based on professional judgment, either seek prior authorization or shall contact the pharmacist and amend or cancel the prescription. The pharmacist shall, within a prompt period based on professional judgment, notify the patient when prior authorization has been obtained or denied or when the prescription has been amended or cancelled.

9. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request solely as the result of a failure of the program (whether by action or inaction), prior authorization shall be immediately and automatically granted without further action by the prescriber and the prescriber shall be notified of this determination. In the instance where a prior authorization determination is not completed within twenty-four hours of the original request for any other reason, a seventy-two hour supply of the medication will be approved by the program and the prescriber shall be notified of the determination.

10. When, in the judgment of the prescriber or the pharmacist, an emergency condition exists, and the prescriber or pharmacist notifies

the program to confirm that such an emergency condition exists, a seventy-two hour emergency supply of the drug prescribed shall be immediately authorized by the program.

11. The department or the panel shall monitor the prior authorization process for prescribing patterns which are suspected of endangering the health and safety of the patient or which demonstrate a likelihood of fraud or abuse. The department or the panel shall take any and all actions otherwise permitted by law to investigate such prescribing patterns, to take remedial action and to enforce applicable federal and state laws.

12. The commissioner may implement all or a portion of the clinical drug review program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

13. No prior authorization under the clinical drug review program shall be required for any prescription under EPIC until the commissioner has made prior authorization applicable to EPIC under section two hundred seventy-five of this article.

14. For the period of eighteen months, commencing with the date of enactment of this article, the commissioner is authorized to continue prior authorization requirements for prescription drugs subject to prior authorization as of one day prior to the enactment of this article and which are not described in subdivision fourteen of section two hundred seventy-two of this article. At the conclusion of the eighteen month period, any such drug shall be subject to the clinical drug review program requirements of this section; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions three through six of this section.

§ 275. Applicability of prior authorization to EPIC. The panel shall, no later than April first, two thousand eight, proceed to make prior authorization under the preferred drug program and the clinical review

drug program, under this article, applicable to prescriptions under EPIC. The panel shall take necessary actions consistent with this article to apply prior authorization under this article to EPIC. Upon determining that the necessary steps have been taken to apply prior authorization under this article to EPIC, the panel shall, with reasonable prior public notice, make prescriptions under EPIC subject to prior authorization under this article as of a specified date. If necessary, the panel may provide that such applicability take effect on separate dates for the preferred drug program and the clinical drug review program.

§ 276. Education and outreach. The department or the panel may conduct education and outreach programs for consumers and health care providers relating to the safe, therapeutic and cost-effective use of prescription drugs and appropriate treatment practices for containing prescription drug costs. The department or the panel shall provide information as to how prescribers, pharmacists, patients and other interested parties can obtain information regarding drugs included on the preferred drug list, whether any change has been made to the preferred drug list since it was last issued, and the process by which prior authorization may be obtained.

§ 277. Review and reports. 1. The commissioner, in consultation with the drug utilization review board, shall undertake periodic reviews, at least annually, of the preferred drug program which shall include consideration of:

(a) the volume of prior authorizations being handled, including data on the number and characteristics of prior authorization requests for particular prescription drugs;

(b) the quality of the program's responsiveness, including the quality of the administrator's responsiveness;

(c) complaints received from patients and providers;

(d) the savings attributable to the state, and to each county and the city of New York, due to the provisions of this article;

(e) the aggregate amount of supplemental rebates received in the

previous fiscal year and in the current fiscal year, to date; and such amounts are to be broken out by fiscal year and by month;

(f) the education and outreach program established by section two hundred seventy-six of this article.

2. The commissioner and the board shall, beginning March thirty-first, two thousand six and annually thereafter, submit a report to the governor and the legislature concerning each of the items subject to periodic review under subdivision one of this section.

3. The commissioner and the board shall, beginning with the commencement of the preferred drug program and monthly thereafter, submit a report to the governor and the legislature concerning the amount of supplemental rebates received.

TITLE II

PRESCRIPTION DRUGS; VARIOUS PROVISIONS

Section 278. Prescription drug retail price lists.

278-a. Exceptions to drug prescription supply during an emergency.

279. Prescriber education.

280. Medicaid drug cap.

280-a. Pharmacy benefit managers.

280-b. Unused prescription drug donation and redispensing program.

280-c. Pharmacy audits by pharmacy benefit managers.

280-d. Patient notification of prescription label change.

§ 278. Prescription drug retail price lists. 1. The department shall make prescription drug retail price lists of pharmacies, with the name and address of each pharmacy, available to the public in a database on its website at all times. The website shall enable consumers to search the database for drug retail prices of pharmacies selected by zip code of the pharmacy and other appropriate factors, including enabling consumers to display and compare prices for one or more selected drugs

as well as for the full list. The website shall enable consumers to download and print displayed information. The website shall accommodate reasonably anticipated and actual public use of the database. The database shall display drug retail prices for the compendium of the one hundred fifty most frequently prescribed drugs received by the department from the department of education under section sixty-eight hundred twenty-six of the education law.

2. The department shall extract pharmacy retail price information, showing the actual price to be paid to the pharmacy by a retail purchaser for any listed drug at the listed dosage, from usual and customary price data collected by the medical assistance program under title eleven of article five of the social services law. Provided, however, that any pharmacy participating in the medical assistance program shall provide the usual and customary price data for the one hundred fifty most frequently prescribed drugs under section sixty-eight hundred twenty-six of the education law to the department through the same mechanism that the usual and customary price data is received under the medical assistance program. If the department is unable to process such data, the pharmacy shall fax or electronically transmit to the department the usual and customary price data for the one hundred fifty most frequently prescribed drugs under section sixty-eight hundred twenty-six of the education law. The prescription drug retail price list database shall be subject to and conform with applicable state and federal requirements, including those concerning privacy, confidentiality and use of information. The commissioner shall seek a waiver of any federal requirement necessary for development and implementation of the database under this section. Upon implementation of this system, this section shall apply in place of any inconsistent provision of section sixty-eight hundred twenty-six of the education law. The prescription drug retail price list database on the department's website shall list a pharmacy's price information extracted under this subdivision as the pharmacy's retail price for each drug. The department shall update the prescription drug retail price list at least weekly using the most recent retail price for each drug for each pharmacy as reasonably practicable.

2-a. Pharmacies which do not provide usual and customary price data in the manner specified in subdivision two of this section shall transmit the drug retail price list compiled pursuant to section sixty-eight hundred twenty-six of the education law to the department in a manner and frequency prescribed by the department and the department shall extract the usual and customary price data information from such drug retail price list; provided that the commissioner may exempt any category of pharmacy not required to compile such list pursuant to section sixty-eight hundred twenty-six of the education law.

3. The prescription drug retail price list database on the department's website shall contain an advisory statement by the department alerting consumers of the need to tell their health care practitioner and pharmacist about all the medications they may be taking and to ask them how to avoid harmful interactions between the drugs, if any. A pharmacy may submit to the department a brief statement, acceptable to the department, to be included on the website in conjunction with the pharmacy's prescription drug retail price information: (a) concerning discounts from its listed retail prices that may be available to consumers and (b) any limitations that the pharmacy may have as to what group or groups of customers it serves.

4. In developing and implementing the prescription drug retail price list database system, the department may seek and shall receive the assistance of the departments of education and law.

5. The commissioner shall provide an interim progress report concerning efforts to develop and implement the database system under this section not later than January thirty-first, two thousand six. The report shall include a projected completion date, a description of obstacles to development and implementation of the database system, and an estimate of the costs to complete the implementation of the database system.

6. As used in this section, "pharmacy" means any place in which drugs or prescriptions are possessed for the purpose of retailing, or in which drugs or prescriptions are retailed, or in which drugs or prescriptions

are by advertising or otherwise offered for sale at retail.

§ 278-a. Exceptions to drug prescription supply during an emergency.

The commissioner shall promulgate a list of prescription drugs that shall not be subject to subsection (c) of section three thousand two hundred forty-two and subsection (c) of section four thousand three hundred twenty-nine of the insurance law. Such list shall include, but not be limited to, all schedule II and schedule III controlled substances.

§ 279. Prescriber education. The department shall develop in collaboration with an academic institution a program designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. Information shall be presented to prescribers by specially-trained pharmacists, nurses or other health professionals to assist the prescriber in making appropriate therapeutic recommendations.

§ 280. Medicaid drug cap. 1. The legislature hereby finds and declares that there is a significant public interest for the Medicaid program to manage drug costs in a manner that ensures patient access while providing financial stability for the state and participating providers. Since two thousand eleven, the state has taken significant steps to contain costs in the Medicaid program by imposing a statutory limit on annual growth. Drug expenditures, however, continually outpace other cost components causing significant pressure on the state, providers, and patient access operating under the Medicaid global cap. It is therefore intended that the department establish a supplemental rebate program as part of a focused and sustained effort to balance the growth of drug expenditures with the growth of total Medicaid expenditures.

2. The commissioner shall review at least annually the department of health state funds Medicaid drug expenditures to identify drugs in the eightieth percentile or higher of total spend, net of rebate or in the

eightieth percentile or higher based on cost per claim, net of rebate.

3. (a) The commissioner may identify and refer drugs in the eightieth percentile or higher of total spend, net of rebate or in the eightieth percentile or higher based on cost per claim, net of rebate, to the drug utilization review board established by section three hundred sixty-nine-bb of the social services law for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

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

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

with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

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

(e) If the commissioner is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall, in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

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

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

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

(iv) the extent of utilization of the drug;

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

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

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

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

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

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

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

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

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

5. (a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the department shall negotiate with the drug's manufacturer for a supplemental rebate to be paid by the manufacturer in an amount not to exceed such target rebate amount.

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

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

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

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

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

(iii) information relating to value-based pricing provided, however,

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

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

(v) the extent of utilization of the drug;

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

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

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

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

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

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

6. (a) After taking into account all rebates and supplemental rebates received by the department, including rebates received to date pursuant

to this section, the commissioner may: subject any drug of a manufacturer referred to the drug utilization review board under this section to prior approval in accordance with existing processes and procedures when such manufacturer has not entered into a supplemental rebate arrangement as required by this section; direct a managed care plan to limit or reduce reimbursement for a drug provided by a medical practitioner if the drug utilization review board recommends a target rebate amount for such drug and the manufacturer has failed to enter into a rebate arrangement required by this section; direct managed care plans to remove from their Medicaid formularies any drugs of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount for and the manufacturer has failed to enter into a rebate arrangement required by this section; promote the use of cost effective and clinically appropriate drugs other than those of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to enter into a rebate arrangement required by this section; allow manufacturers to accelerate rebate payments under existing rebate contracts; and such other actions as authorized by law. The commissioner shall provide written notice to the legislature at least thirty days prior to taking action pursuant to this paragraph.

(b) The commissioner shall be authorized to take the actions described in paragraph (a) of this subdivision. In addition, no such actions shall be deemed to supersede the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article or the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law; provided further that nothing in this section shall prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition.

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

respectively, and what savings were achieved through other means and how such savings were calculated and implemented.

§ 280-a. Pharmacy benefit managers. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Health plan " means an entity for which a pharmacy benefit manager provides pharmacy benefit management services and that is a health benefit plan or other entity that approves, provides, arranges for, or pays or reimburses in whole or in part for health care items or services, to include at least prescription drugs, for a substantial number of beneficiaries who work or reside in this state. The superintendent shall determine, in his or her sole discretion, by regulation how the phrase "a substantial number of beneficiaries who work or reside in this state" shall be interpreted.

(b) "Pharmacy benefit management services" means the management or administration of prescription drug benefits for a health plan, directly or through another entity, and regardless of whether the pharmacy benefit manager and the health plan are related, or associated by ownership, common ownership, organization or otherwise; including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including but not limited to, any of the following:

(i) mail service pharmacy;

(ii) claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(iii) clinical or other formulary or preferred drug list development or management;

(iv) negotiation or administration of rebates, discounts, payment differentials, or other incentives, for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(v) patient compliance, therapeutic intervention, or generic substitution programs;

(vi) disease management;

(vii) drug utilization review or prior authorization;

(viii) adjudication of appeals or grievances related to prescription

drug coverage;

(ix) contracting with network pharmacies; and

(x) controlling the cost of covered prescription drugs.

(c) "Pharmacy benefit manager" means any entity that performs pharmacy benefit management services for a health plan.

(d) "Maximum allowable cost price" means a maximum reimbursement amount set by the pharmacy benefit manager for therapeutically equivalent multiple source generic drugs.

(e) "Controlling person" means any person or other entity who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of a pharmacy benefit manager.

(f) "Covered individual" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a health plan.

(g) "License" means a license to be a pharmacy benefit manager, under article twenty-nine of the insurance law.

(h) "Spread pricing" means the practice of a pharmacy benefit manager retaining an additional amount of money in addition to the amount paid to the pharmacy to fill a prescription.

(i) "Superintendent" means the superintendent of financial services.

2. Duty, accountability and transparency. (a) (i) The pharmacy benefit manager shall have a duty and obligation to perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism.

(ii) In addition to the duties as may be prescribed by regulation pursuant to article twenty-nine of the insurance law:

(1) A pharmacy benefit manager interacting with a covered individual shall have the same duty to a covered individual as the health plan for whom it is performing pharmacy benefit management services.

(2) A pharmacy benefit manager shall have a duty of good faith and fair dealing with all parties, including but not limited to covered individuals and pharmacies, with whom it interacts in the performance of pharmacy benefit management services.

(b) All funds received by the pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust and shall be used or distributed only pursuant to the pharmacy benefit manager's contract with the health plan

or applicable law; including any administrative fee or payment to the pharmacy benefit manager expressly provided for in the contract to compensate the pharmacy benefit manager for its services. Any funds received by the pharmacy benefit manager through spread pricing shall be subject to this paragraph. In addition to any other power conferred by law the superintendent shall have the authority to prescribe rules concerning pharmacy benefit manager administrative fees, including limitations on their form and use.

(c) The pharmacy benefit manager shall account, annually or more frequently to the health plan for any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits received by the pharmacy benefit manager. The health plan shall have access to all financial and utilization information of the pharmacy benefit manager in relation to pharmacy benefit management services provided to the health plan.

(d) The pharmacy benefit manager shall disclose in writing to the health plan the terms and conditions of any contract or arrangement between the pharmacy benefit manager and any party relating to pharmacy benefit management services provided to the health plan including but not limited to, dispensing fees paid to the pharmacies.

(e) The pharmacy benefit manager shall disclose in writing to the health plan any activity, policy, practice, contract or arrangement of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the health plan.

(f) Any information required to be disclosed by a pharmacy benefit manager to a health plan under this section that is reasonably designated by the pharmacy benefit manager as proprietary or trade secret information shall be kept confidential by the health plan, except as required or permitted by law, including disclosure necessary to prosecute or defend any legitimate legal claim or cause of action. Designation of information as proprietary or trade secret information under this subdivision shall have no effect on the obligations of any pharmacy benefit manager or health plan to provide that information to the department of health or the department of financial services.

(g) The superintendent, in consultation with the commissioner may make regulations defining, limiting, and relating to the duties, obligations,

requirements and other provisions relating to pharmacy benefit managers under this subdivision.

3. Prescriptions. A pharmacy benefit manager may not substitute or cause the substituting of one prescription drug for another in dispensing a prescription, or alter or cause the altering of the terms of a prescription, except with the approval of the prescriber or as explicitly required or permitted by law, including regulations of the department of financial services or the department of health. The superintendent and commissioner, in coordination with each other, are authorized to promulgate regulations to determine when substitution of prescription drugs may be required or permitted.

4. Appeals. A pharmacy benefit manager shall, with respect to contracts between a pharmacy benefit manager and a pharmacy or, alternatively, a pharmacy benefit manager and a pharmacy's contracting agent, such as a pharmacy services administrative organization, include a reasonable process to appeal, investigate and resolve disputes regarding multi-source generic drug pricing. The appeals process shall include the following provisions:

(a) the right to appeal by the pharmacy and/or the pharmacy's contracting agent shall be limited to thirty days following the initial claim submitted for payment;

(b) a telephone number through which a network pharmacy may contact the pharmacy benefit manager for the purpose of filing an appeal and an electronic mail address of the individual who is responsible for processing appeals;

(c) the pharmacy benefit manager shall send an electronic mail message acknowledging receipt of the appeal. The pharmacy benefit manager shall respond in an electronic message to the pharmacy and/or the pharmacy's contracting agent filing the appeal within seven business days indicating its determination. If the appeal is determined to be valid, the maximum allowable cost for the drug shall be adjusted for the appealing pharmacy effective as of the date of the original claim for payment. The pharmacy benefit manager shall require the appealing pharmacy to reverse and rebill the claim in question in order to obtain the corrected reimbursement;

(d) if an update to the maximum allowable cost is warranted, the pharmacy benefit manager or covered entity shall adjust the maximum allowable cost of the drug effective for all similarly situated pharmacies in its network in the state on the date the appeal was determined to be valid; and

(e) if an appeal is denied, the pharmacy benefit manager shall identify the national drug code of a therapeutically equivalent drug, as determined by the federal Food and Drug Administration, that is available for purchase by pharmacies in this state from wholesalers registered pursuant to subdivision four of section sixty-eight hundred eight of the education law at a price which is equal to or less than the maximum allowable cost for that drug as determined by the pharmacy benefit manager.

5. Contract provisions. No pharmacy benefit manager shall, with respect to contracts between such pharmacy benefit manager and a pharmacy or, alternatively, such pharmacy benefit manager and a pharmacy's contracting agent, such as a pharmacy services administrative organization:

(a) prohibit or penalize a pharmacist or pharmacy from disclosing to an individual purchasing a prescription medication or service information regarding:

(i) the cost of the prescription medication or service to the individual, or the cost of the prescription medication or service to the pharmacy and the pharmacy's reimbursement for that prescription medication or service; or

(ii) the availability of any therapeutically equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price; or

(b) charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid. If an individual pays a copayment, the pharmacy shall retain the adjudicated costs and the pharmacy benefit manager shall not redact or recoup the adjudicated cost.

§ 280-b. Unused prescription drug donation and redispensing program.

1. As used in this section:

(a) "Donor entity" means a manufacturer, wholesaler, or distributor of prescription drugs; a pharmacy; or a hospital authorized under article twenty-eight of this chapter.

(b) "Recipient entity" means a manufacturer, wholesaler, or distributor of prescription drugs; a pharmacy; or a hospital authorized under article twenty-eight of this chapter.

(c) "Third party intermediary" means a not-for-profit organization that facilitates the donation or transfer of prescription drugs under this section but does not take possession or ownership of the prescription drugs.

(d) "Redispense" means to dispense a prescription drug that was donated and received under this section.

2. The commissioner shall make regulations governing the donation and redispensing of unused prescription drugs under this section.

3. A donor entity may donate unused prescription drugs to a recipient entity, directly or through a third-party intermediary, in a secure manner, ensuring the privacy of any individuals for whom the prescription drugs were initially dispensed or intended to be dispensed. Prescription drugs redispensed under this section shall be inspected by a pharmacist or other licensed health care provider as provided by regulations. The participation of any donor or recipient entity in redispensing shall be voluntary.

4. Only prescription drugs received by the recipient entity in tamper-evident packaging as defined by United States pharmacopoeia (USP) general chapter 659, or in unit-dose or multiple-dose packaging, may be redispensed. No prescription drugs may be redispensed that:

(a) show evidence of being adulterated or misbranded;

(b) show evidence of packaging having been tampered with;

(c) will expire before the use by the patient based on the prescribing practitioner's directions for use;

(d) or have been excluded from the program under regulations of the commissioner.

5. A prescription drug shall not be redispensed if it is restricted to a patient registered with the drug's manufacturer under federal Food and Drug Administration requirements including, but not limited to, those relating to risk evaluation and mitigation strategies (REMS), unless the redispensing is effectively restricted to ensure that the prescription drug is only dispensed in accordance with those requirements as applicable.

6. A recipient entity may also be a donor entity.

7. Prescription drugs having passed inspection under subdivision three of this section may be repackaged or prepackaged by the recipient entity prior to further redispensing.

8. Recipient entities shall give priority for redispensing to patients who are indigent, uninsured, or under-insured.

9. A redispensed prescription drug shall not be resold by any person or entity. However, this subdivision does not bar the payment of reasonable processing fees.

10. No person or entity shall be subject to criminal or civil liability, or professional discipline for any action taken in reasonable good faith compliance with this section, except under otherwise applicable grounds for liability.

11. The department shall work with prospective and approved donor entities, recipient entities and third-party intermediaries to educate them about redispensing and promote participation in redispensing. The department shall maintain a list of recipient entities, and third-party intermediaries and publish it on the department's website.

§ 280-c. Pharmacy audits by pharmacy benefit managers. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Pharmacy benefit manager" shall have the same meaning as in

section two hundred eighty-a of this article.

(b) "Pharmacy" shall mean a pharmacy that has contracted with a pharmacy benefit manager for the provision of pharmacy services.

2. When conducting an audit of a pharmacy's records, a pharmacy benefit manager shall:

(a) not conduct an on-site audit of a pharmacy at any time during the first three calendar days of a month;

(b) notify the pharmacy or its contracting agent no later than fifteen days before the date of initial on-site audit. Such notification to the pharmacy or its contracting agent shall be in writing delivered either (i) by mail or common carrier, return receipt requested, or (ii) electronically with electronic receipt confirmation, addressed to the supervising pharmacist of record and pharmacy corporate office where applicable, at least fifteen days before the date of an initial on-site audit;

(c) limit the audit period to twenty-four months after the date a claim is submitted to or adjudicated by the pharmacy benefit manager;

(d) include in the written advance notice of an on-site audit the list of specific prescription numbers to be included in the audit that may or may not include the final two digits of the prescription numbers;

(e) use the written and verifiable records of a hospital, physician or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law;

(f) limit the number of prescriptions audited to no more than one hundred randomly selected in a twelve-month period, except in cases of fraud;

(g) provide the pharmacy or its contracting agent with a copy of the preliminary audit report within forty-five days after the conclusion of the audit;

(h) be allowed to conduct a follow-up audit on-site if a remote or desk audit reveals the necessity for a review of additional claims;

(i) in the case of invoice audits, accept as validation invoices from any wholesaler registered with the department of education from which the pharmacy has purchased prescription drugs or, in the case of durable medical equipment or sickroom supplies, invoices from an authorized

distributor other than a wholesaler;

(j) provide the pharmacy or its contracting agent with the ability to provide documentation to address a discrepancy or audit finding, provided that such documentation must be received by the pharmacy benefit manager no later than the forty-fifth day after the preliminary audit report was provided to the pharmacy or its contracting agent. The pharmacy benefit manager shall consider a reasonable request from the pharmacy for an extension of time to submit documentation to address or correct any findings in the report; and

(k) provide the pharmacy or its contracting agent with the final audit report no later than sixty days after the initial audit report was provided to the pharmacy or its contracting agent.

3. Any claim that was retroactively denied for a clerical error, typographical error, scrivener's error or computer error shall be paid if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged or the error results in actual financial loss to the entity. A clerical error is an error that does not result in actual financial harm to the covered entity or consumer and does not include the dispensing of an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person.

4. This section shall not apply to:

(a) audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods; or

(b) audits of claims paid for by federally funded programs; or

(c) concurrent reviews or desk audits that occur within three business days of transmission of a claim and where no chargeback or recoupment is demanded.

§ 280-d. Patient notification of prescription label change. A health care prescriber shall inform the patient if such prescriber has included or has requested to include the name or address of the prescribing health care practice instead of the name of such prescriber on the

prescription label when prescribing mifepristone or misoprostol.

TITLE III

PRESCRIPTION FORMS, ELECTRONIC PRESCRIBING AND LANGUAGE ASSISTANCE

Section 281. Official New York state prescription forms.

§ 281. Official New York state prescription forms. 1. In addition to the requirements of section sixty-eight hundred ten of the education law or article thirty-three of this chapter, all prescriptions written in this state by a person authorized by this state to issue such prescriptions shall be on serialized official New York state prescription forms provided by the department. Such forms shall be furnished to practitioners authorized to write prescriptions and to institutional dispensers, and shall be non-reproducible and non-transferable. The commissioner, in consultation with the commissioner of education, may promulgate emergency regulations for the electronic transmission of prescriptions from prescribers to pharmacists or for ordering and filling requirements of prescription drugs for prescriptions written for recipients eligible for medical assistance pursuant to title eleven of article five of the social services law, for participants in the program for elderly pharmaceutical insurance coverage pursuant to title three of article two of the elder law and for prescriptions written pursuant to article thirty-three of this chapter. Nothing in this section shall prohibit the commissioner in consultation with the commissioner of education from promulgating any additional emergency regulations in furtherance of this subdivision.

2. The commissioner, in consultation with the commissioner of education, shall promulgate regulations requiring that prescription forms and electronic prescriptions include: (a) a section wherein prescribers may indicate whether an individual is limited English proficient, as defined in section sixty-eight hundred twenty-nine of the education law; and (b) if the patient is limited English proficient, a line where the prescriber may specify the preferred language indicated by the patient. Failure to include such indication on the part of the

prescriber shall not invalidate the prescription.

3. On or before December thirty-first, two thousand twelve, the commissioner shall promulgate regulations, in consultation with the commissioner of education, establishing standards for electronic prescriptions. Notwithstanding any other provision of this section or any other law to the contrary, effective three years subsequent to the date on which such regulations are promulgated, no person shall issue any prescription in this state unless such prescription is made by electronic prescription from the person issuing the prescription to a pharmacy in accordance with such regulatory standards, except for prescriptions: (a) issued by veterinarians; (b) issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure, as set forth in regulation; (c) issued by practitioners who have received a waiver or a renewal thereof for a specified period determined by the commissioner, not to exceed one year, from the requirement to use electronic prescribing, pursuant to a process established in regulation by the commissioner, in consultation with the commissioner of education, due to economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner; (d) issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription as required by this subdivision, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition, provided that if such prescription is for a controlled substance, the quantity of controlled substances does not exceed a five day supply if the controlled substance were used in accordance with the directions for use; or (e) issued by a practitioner to be dispensed by a pharmacy located outside the state, as set forth in regulation.

3-a. A pharmacy that receives an electronic prescription from the person issuing the prescription may, if the prescription has not been dispensed and at the request of the patient or a person authorized to make the request on behalf of the patient, immediately transfer or

forward such prescription to an alternative pharmacy designated by the requesting party.

4. In the case of a prescription for a controlled substance issued by a practitioner under paragraph (b) of subdivision three of this section, the practitioner shall indicate in the patient's health record that the prescription was issued other than electronically due to temporary technological or electrical failure.

5. In the case of a prescription for a controlled substance issued by a practitioner under paragraph (d) or (e) of subdivision three of this section, the practitioner shall, upon issuing such prescription, indicate in the patient's health record either that the prescription was issued other than electronically because it (a) was impractical to issue an electronic prescription in a timely manner and such delay would have adversely impacted the patient's medical condition, or (b) was to be dispensed by a pharmacy located outside the state.

6. The waiver process established in regulation pursuant to paragraph (c) of subdivision three of this section shall provide that a practitioner prescribing under a waiver must notify the department in writing promptly upon gaining the capability to use electronic prescribing, and that a waiver shall terminate within a specified period of time after the practitioner gains such capability.

* 7. Notwithstanding any other provision of this section or any other law to the contrary, a practitioner shall not be required to issue prescriptions electronically if he or she certifies to the department, in a manner specified by the department, that he or she will not issue more than twenty-five prescriptions during a twelve month period. Prescriptions in both oral and written form for both controlled substances and non-controlled substances shall be included in determining whether the practitioner will reach the limit of twenty-five prescriptions.

(a) A certification shall be submitted in advance of the twelve-month certification period, except that a twelve-month certification submitted on or before July first, two thousand sixteen, may begin March twenty-seven, two thousand sixteen.

(b) A practitioner who has made a certification under this subdivision may submit an additional certification on or before the expiration of the current twelve-month certification period, for a maximum of three twelve-month certifications.

(c) A practitioner may make a certification under this subdivision regardless of whether he or she has previously received a waiver under paragraph (c) of subdivision three of this section.

* NB Repealed June 1, 2029

ARTICLE 2-B DRUG TAKE BACK

Section 290. Definitions.

291. Drug take back.

292. Collection.

293. Violations.

294. Jurisdiction.

§ 290. Definitions. As used in this article, unless the context clearly requires otherwise:

1. "Authorized collector" means: (a) a person, company, corporation or other entity that is registered with the United States Drug Enforcement Administration to collect controlled substances for the purposes of safe disposal and destruction; (b) a law enforcement agency; or (c) a person, company, corporation or other entity authorized by the department to provide alternative collection methods for covered drugs that are not controlled substances.

2. "Covered drug" means any substance recognized as a drug under 21 USC § 321(g)(1), as amended, and any regulations promulgated thereunder that is sold, offered for sale or dispensed in the state, whether directly or through a wholesaler, in any form including prescription and nonprescription drugs, drugs in medical devices and combination products, brand and generic drugs and drugs for veterinary use; provided however, covered drug shall not include: (a) vitamins or supplements;

(b) herbal-based remedies and homeopathic drugs, products or remedies; (c) cosmetics, soap (with or without germicidal agents), laundry detergent, bleach, household cleaning products, shampoos, sunscreens, toothpaste, lip balm, antiperspirants or other personal care products that are regulated as both cosmetics and nonprescription drugs under the Federal Food, Drug, and Cosmetic Act; (d) pet pesticide products contained in pet collars, powders, shampoos, topical applications, or other forms; (e) drugs that are biological products as defined in subdivision twenty-seven of section sixty-eight hundred two of the education law if the manufacturer already provides a take back program; (f) drugs for which a manufacturer provides a take back program as part of a Federal Food and Drug Administration managed risk evaluation and mitigation strategy; (g) emptied injector products or emptied medical devices and their component parts or accessories; and (h) drugs that are used solely in a clinical setting.

3. "Manufacturer" means a person, company, corporation or other entity engaged in the manufacture of covered drugs sold in the state. Manufacturer does not include a repackager or wholesaler.

4. "Pharmacies" means all pharmacies registered under section sixty-eight hundred eight of the education law that are part of a group of ten or more establishments that conduct business under the same name, or operate under a common ownership or management, or pursuant to a franchise agreement with the same franchisor, and all nonresident pharmacies registered pursuant to section sixty-eight hundred eight-b of the education law that provide covered drugs to state residents by mail.

5. "Drug take back organization" means an organization designated by a manufacturer or a group of manufacturers to act as an agent on behalf of the manufacturer or group of manufacturers to operate and implement a drug take back program as authorized by this article.

6. "Wholesaler" means any person, company, corporation or other entity that sells or distributes drugs and covered drugs for resale to an entity in the state other than a consumer.

7. "Repackager" means an entity that owns or operates an establishment that repacks and relabels a product or package containing a covered drug for further sale or for distribution without further transaction.

§ 291. Drug take back. 1. Any manufacturer of a covered drug shall:

(a) operate a drug take back program approved by the department individually or jointly with other manufacturers;

(b) enter into an agreement with a drug take back organization which shall operate a drug take back program approved by the department; or

(c) enter into an agreement with the department to operate a drug take back program on its behalf.

2. Any manufacturer of a covered drug, individually or jointly, or a drug take back organization contracted by a manufacturer of a covered drug shall within one hundred eighty days from the effective date of this section submit to the department, in a manner and form determined by the department, a proposed drug take back program that meets, at a minimum, the following requirements:

(a) Certifies the drug take back program will accept all covered drugs regardless of who produced them;

(b) Provides contact information for the person submitting the planned drug take back program with whom the department shall direct all inquiries;

(c) Details a collection system to provide convenient, ongoing collection services to all persons seeking to dispose of covered drugs pursuant to section two hundred ninety-two of this article that is geographically distributed in a way to ensure access in rural and underserved areas;

(d) Describes other collection methods by which covered drugs will be collected by authorized collectors;

(e) Explains how covered drugs will be safely and securely tracked and handled from collection through final disposal and destruction, policies to ensure security and compliance with all applicable laws and regulations including disposal and destruction at a permitted waste disposal facility meeting federal requirements;

(f) Describes the public education and outreach activities that will

be undertaken which shall include advertising of collection locations on a website and through use of signage and other written materials, and how effectiveness will be evaluated;

(g) Details how the costs of pharmacy collection and other authorized collectors will be reimbursed which shall include costs retroactive to the effective date of this article, and where more than one manufacturer will be involved in the planned drug take back program, a plan for the fair and reasonable manner of allocated costs among the participants in such program such that the costs paid by each manufacturer is reasonably related to the volume or value of covered drugs sold in the state; and

(h) Provides any further information deemed appropriate by the department.

3. Within thirty days of the effective date of this section, each wholesaler that sells covered drugs in or into the state shall provide the department with a list of manufacturers that produce covered drugs. The department may request updated lists at its discretion.

4. A manufacturer, individually or jointly, must pay all administrative and operational fees associated with the drug take back program, including the cost of collecting, transporting and disposing of covered drugs from pharmacies and other authorized collectors and the recycling or disposal, or both, of packing collected with the covered drug. Manufacturers shall also pay costs incurred by the state in the administration and enforcement of the drug take back program. Exclusive of fines and penalties, the state shall only recover its actual cost of administration and enforcement. In instances where manufacturers jointly conduct a drug take back program, the costs of administration and enforcement shall be fairly and reasonably allocated such that the portion of costs is reasonably related to the volume or value of covered drugs the manufacturers sell in the state. No manufacturer may charge a point-of-sale or other fee to consumers, or a fee that could be passed on to consumers, to recoup the cost of their drug take back program.

5. Within sixty days of receipt of a proposed drug take back program, the department, in consultation with the department of environmental conservation, shall determine whether such proposed drug take back

program complies with the requirements of this article and notify the applicant. The department may conduct a noticed public hearing prior to approval. If the drug take back program is approved, the department shall notify the applicant in writing. If the drug take back program is not approved, the department shall notify the applicant in writing and the applicant shall submit a revised drug take back program proposal within thirty days. If the department rejects the subsequent proposal, the manufacturer or manufacturers at issue shall be out of compliance with this article and subject to the enforcement provisions pursuant to section two hundred ninety-four of this article. The department shall provide, and update annually, on its website a list of all manufacturers participating in a drug take back program approved by the department.

6. At least every three years, a manufacturer, jointly or individually, or a drug take back organization shall update its drug take back program and submit an updated proposal to the department. A manufacturer who begins to offer a covered drug in the state after the effective date of this article, shall provide evidence of joining an existing approved drug take back program or submit a proposal for a drug take back program within ninety days following the initial offer for sale of a covered drug. Any proposed change to a drug take back program shall be submitted in writing and approved by the department prior to any change.

7. Each approved drug take back program shall report to the department at a date and manner set by the department. The department shall submit an annual report to the governor, speaker of the assembly and temporary president of the senate by January first detailing all program activities, the weight collected by each program, a description of collection activities, the name and location of all collection sites, public education and outreach activities, an evaluation of the efficacy of the program and each collection method, and any manufacturer out of compliance or subject to penalties pursuant to section two hundred ninety-four of this article.

§ 292. Collection. 1. All pharmacies shall provide for the safe

collection of drugs, which shall include:

(a) Offering drug collection by one or more of the following methods:

(i) On-site collection, dropbox, or receptacle meeting federal standards;

(ii) Mail-back collection by prepaid envelopes as authorized by federal law and regulation; or

(iii) Other federal drug enforcement agency approved methods of collection.

(b) Signage prominently displayed advertising such drug collection to consumers.

2. All drug take back program operators shall notify other potential authorized collectors of the opportunity to serve as an authorized collector for the drug take back program. Participation of authorized collectors besides pharmacies shall be voluntary.

3. All costs of pharmacies and other authorized collectors shall be paid or reimbursed by the manufacturer, jointly or individually, as part of the drug take back programs required by this article.

4. For any city with a population of one hundred twenty-five thousand or more as of the last decennial census, the commissioner shall establish by regulation a distribution plan that ensures that on-site collection receptacle or dropbox placement shall be reasonably accessible to all residents and that provides for program cost efficiency.

5. Pharmacies providing for mail-back collection as part of the drug take back program shall provide a voucher for a prepaid envelope upon dispensing a covered drug. Such voucher shall include information on drug take back and safe drug disposal methods.

§ 293. Violations. Violation of this article shall be subject to fines pursuant to section twelve of this chapter. Each day in which the violation continues shall constitute a separate violation.

§ 294. Jurisdiction. Jurisdiction of all matters pertaining to drug disposal by this article is vested exclusively in the state. Any provision of any local law or ordinance, or any rule or regulation promulgated prior to, or upon the effective date of this section, shall be preempted.

ARTICLE 3

LOCAL HEALTH ORGANIZATION

- Title I. Local boards of health; general provisions (§§ 300-312).
II. Local health officers (§§ 320-329).
III. County and part-county health districts (§§ 340-357).
IV. Certain cities (§§ 360-378).
V. State park health districts (§§ 380-383).
VI. Consolidated health districts (§§ 390-399).

TITLE I

LOCAL BOARDS OF HEALTH; GENERAL PROVISIONS

- Section 300. Local boards of health; continuation.
301. Local boards of health; certain cities; appointment.
302. Local boards of health; villages and towns; organization.
303. Local boards of health; notice of organization.
304. Local boards of health; town boards; jurisdiction; appropriations.
305. Local boards of health; compensation and expenses of members.
306. Local boards of health; expenses; payment.
307. Local boards of health; meetings.
308. Local boards of health; general powers and duties.
309. Local boards of health; quasi-judicial powers; enforcement.
310. Local boards of health; modification of orders by commissioner.
311. Local boards of health; towns and villages; application of law.
312. City of New York; exceptions and limitations.

§ 300. Local boards of health; continuation. There shall continue to be local boards and departments of health and health officers in the several counties, cities, villages and towns of the state except as otherwise provided by law.

§ 301. Local boards of health; certain cities; appointment. 1. In cities under fifty thousand population according to the latest federal or state census or enumeration, the board of health shall consist of the mayor of the city who shall be its president, and six other persons, one of whom shall be a competent physician who shall be appointed by the common council, upon the nomination of the mayor, and shall hold office for three years.

2. Appointments of members of such boards shall be made for such shorter terms as at any time may be necessary, in order that the terms of two appointed members shall expire annually.

§ 302. Local boards of health; villages and towns; organization. 1. In villages the board of health shall consist of the board of trustees of the village.

2. In towns the board of health shall consist of the town board.

§ 303. Local boards of health; notice of organization. Notice of the membership and organization of every local board of health shall be given forthwith by such board to the department.

§ 304. Local boards of health; town boards; jurisdiction; appropriations. A town board of health shall not have jurisdiction over any city or incorporated village or part of such city or village in such town unless otherwise provided by law. Appropriations for a town board

of health in a town in which there are one or more incorporated villages shall be a charge upon the taxable property of that part of the town outside of any incorporated village and shall be assessed, levied and collected therefrom in the same manner as other town charges levied on property outside of incorporated villages.

§ 305. Local boards of health; compensation and expenses of members.

1. The members of town boards and of village boards of trustees shall not receive additional compensation by reason of serving as members of boards of health, except that in the case of a consolidated health district, members of the board of health of such district, whether or not they are members of a town board or a village board of trustees, shall be allowed a per diem compensation of not more than ten dollars for each calendar day in actual attendance at a meeting of the board of health of the district, to be fixed and determined by the board of health of the district. Such per diem compensation in the case of any member shall not exceed the total sum of one hundred and fifty dollars in any one year.

2. Members of boards of health of consolidated districts shall also be allowed their actual and necessary expenses.

3. The compensation and expenses of members of boards of health of consolidated health districts shall be audited and paid in the same manner as the other expenses of the consolidated health districts.

§ 306. Local boards of health; expenses; payment. 1. All expenses incurred by any local board of health in the performance of the duties imposed upon it or its members by law shall be a charge upon the municipality, and shall be audited, levied, collected and paid in the same manner as the other charges of, or upon, the municipality are audited, levied, collected and paid.

2. The taxable property of any incorporated village shall not be subject to taxation for maintaining any town board of health, or for any

expenditure authorized by the town board, but the costs and expenditures of the town board shall be assessed and collected exclusively on the taxable property of the town situate outside of any such village, unless otherwise provided by law.

§ 307. Local boards of health; meetings. 1. Every local board of health shall meet at stated intervals to be fixed by it.

2. The presiding officer of every local board of health may call special meetings thereof when in his judgment the protection of the public health of the municipality requires it, and shall call such a meeting upon the petition of at least twenty-five residents thereof, of full age, setting forth the necessity of such meetings.

3. Any matter within the jurisdiction of a town or village board of health may be considered and acted upon at any regular or special meeting of such town board or village board of trustees.

§ 308. Local boards of health; general powers and duties. Subject to the provisions of this chapter and of the sanitary code, every local board of health shall:

(a) prescribe the duties and powers of the local health officer, who shall be its chief executive officer;

(b) direct the local health officer in the performance of his duties;

(c) fix the compensation of the local health officer in accordance with the provisions of section three hundred twenty-three of this chapter;

(d) make and publish, from time to time, such orders and regulations, not inconsistent with the provisions of the sanitary code, as it may deem necessary and proper for the preservation of life and health and the execution and enforcement of this chapter in the municipality a copy of such orders and regulations to be filed with the county health commissioner, if any, otherwise with the state district health officer;

(e) make, without publication thereof, such orders and regulations for the suppression of nuisances and concerning all other matters in its

judgment detrimental to the public health in special or individual cases, not of general application, and serve copies thereof upon the owner or occupant of any premises whereon such nuisances or other matters may exist, or upon which may exist the cause of other nuisances to other premises, or cause the same to be conspicuously posted thereon; and,

(f) maintain actions in any court of competent jurisdiction to restrain by injunction violations of its orders and regulations, or otherwise to enforce such orders and regulations.

§ 309. Local boards of health; quasi-judicial powers; enforcement. 1.
Every local board of health may:

(a) issue subpoenas which shall be regulated by the civil practice law and rules;

(b) compel the attendance of witnesses;

(c) administer oaths to witnesses and compel them to testify;

(d) by resolution, designate one of its members to sign and issue such subpoenas;

(e) issue warrants to any peace officer, acting pursuant to his special duties, or police officer of the municipality to apprehend and remove such person or persons as cannot otherwise be subjected to its orders or regulations, and to the sheriff of the county to bring to its aid the power of the county whenever it shall be necessary to do so;

(f) prescribe and impose penalties for the violation of or failure to comply with any of its orders or regulations, or any of the regulations of the state sanitary code, not exceeding two thousand dollars for a single violation or failure, to be sued for and recovered by it in any court of competent jurisdiction; and

(g) appoint one or more hearing officers as shall be necessary to carry out its functions and duties, The hearing officer shall have the same powers possessed by the board to hold and conduct hearings. The hearing officer shall function under the supervision of the local board and shall make findings of fact and recommendations to the board.

2. No subpoena shall be served outside the jurisdiction of the board of health issuing it, and no witness shall be interrogated or compelled

to testify upon matters not related to the public health.

3. Every warrant issued by a local board of health shall be forthwith executed by the officer to whom directed, who shall have the same powers and be subject to the same duties in the execution thereof, as if it had been duly issued out of a court of record of the state.

4. Nothing in this section contained shall be construed to alter or repeal any existing provision of law declaring such violations or any of them misdemeanors or felonies or prescribing a penalty therefor.

5. The penalty imposed by this section may be released or compromised by the commissioner.

§ 310. Local boards of health; modification of orders by commissioner. The commissioner may annul or modify an order, regulation, by-law or ordinance of a local board of health concerning a matter which in his judgment affects the public health beyond the territory over which such local board of health has jurisdiction.

§ 311. Local boards of health; towns and villages; application of law. The provisions contained in this article as to the local boards of health, and for the appointment of local health officers shall apply to all towns and villages, whether such villages are organized under general or special laws.

§ 312. City of New York; exceptions and limitations. Unless otherwise expressly provided, the provisions of this article except section three hundred ten of this chapter shall not apply to the city of New York.

TITLE II

LOCAL HEALTH OFFICERS

Section 320. Local health officer; appointment; residence.

- 321. Local health officer; power of commissioner to appoint; expenses.
- 322. Local health officer; term of office; removal.
- 323. Local health officer; compensation and expenses.
- 324. Local health officer; general powers and duties.
- 325. Local health officer; practice of medicine prohibited; certain cities.
- 326. Local health officer; temporary or acting; appointment; compensation; powers.
- 327. Local health officer; nurses; appointment.
- 328. Local health officer; nurses; duties.
- 329. Local health officer; immunity from personal liability.

§ 320. Local health officer; appointment; residence. 1. Except in the cities whose charters otherwise provide, and except as hereinafter provided for joint appointment by two or more local boards of health of one health officer for the municipalities joining in such appointment, and except in those local health districts within the area of a county or part-county health district, each local board of health shall appoint a health officer of the municipality. A member of the appointing board is not eligible to be appointed as the health officer. Such health officer shall be a citizen and qualified as provided in the sanitary code. Such qualifications shall be determined by the public health council, in consultation with the rural health council. Notwithstanding the provisions of any general or local law or charter, a person who is qualified as provided in the sanitary code at the time of his appointment shall be eligible for appointment as health officer.

2. The health officer need not reside within the village or town for which he is appointed.

3. The local boards of health of a town and village, or for two or more towns or villages, jointly, may appoint one health officer to be the health officer for the several municipalities joining in the appointment, upon the authorization of a resolution or ordinance duly adopted by each of the respective town boards or boards of trustees of

the villages affected, with the written approval of the commissioner.

§ 321. Local health officer; power of commissioner to appoint; expenses. 1. If any local board of health fails to appoint a health officer qualified as provided in the sanitary code, the commissioner may exercise the powers of a health officer in such municipality, or designate a health officer qualified as provided in the sanitary code, to exercise such powers.

2. The expenses lawfully incurred by the commissioner in such municipality shall be a charge upon and paid by such municipality until such time as a local health officer shall be appointed therein, whereupon the jurisdiction conferred by this section on the commissioner or other person designated by him shall cease.

§ 322. Local health officer; term of office; removal. 1. The term of office of the health officer of a municipality shall be four years and he shall hold office until his successor is appointed and qualifies.

2. (a) The health officer may be removed from office for just cause by the local board of health or by the commissioner after a hearing upon notice. Removal of the health officer by the local board of health shall be subject to the approval of the commissioner.

(b) Where a health officer has been appointed jointly, by two or more local boards of health, the power of a local board of health to remove the health officer shall in such case be exercised jointly by the local boards participating in the appointment.

§ 323. Local health officer; compensation and expenses. 1. Every local board of health shall fix the compensation of the local health officer, which in the case of the health officer of a city, town, village and consolidated health district having a population of eight thousand or less, shall not be less than the equivalent of fifteen cents per annum per inhabitant, including Indians on reservations, of the

city, town, village or consolidated health district, according to the latest federal or state census or enumeration; and in a city, town, village and consolidated health district having a population of more than eight thousand, shall not be less than twelve hundred dollars per annum.

2. In addition to his compensation as provided herein, the board of health shall allow the actual and reasonable expenses of the health officer (a) in the performance of his official duties, (b) in going to, attending and returning from the annual health conference or equivalent meeting held yearly within the state (c) in going to, attending and returning from conferences called by the commissioner or his authorized representative and (d) in going to, attending and returning from conferences called by the state district health officer of the district. The board of health, in lieu of allowing the actual and reasonable expenses for travel of said health officer, may determine by resolution to allow him an amount not to exceed eight cents per mile for the use of his own automobile for each mile actually and necessarily traveled by him in the performance of the duties of his office and in going to, attending and returning from any of such conferences.

4. (a) The regular compensation of a health officer appointed jointly by two or more local boards of health for two or more towns or villages shall be fixed jointly by such boards in such sum as they shall determine in accordance with the provisions of this section, and such compensation, together with the expenses of the health officer in the performance of his duties and in attending the annual sanitary conference or equivalent meeting and conferences called by the state district health officer, shall be allowed by the local boards of health and paid by the municipalities in the proportions to each as shall have been determined in the resolutions or ordinances authorizing the joint appointment of the health officer.

(b) The resolution or ordinance of the towns and villages authorizing the local boards of health of said towns or villages to appoint a health officer for the said towns or villages pursuant to subdivision three of section three hundred twenty of this chapter, shall state the proportion of compensation and expenses of the health officer for which each such

town or village shall be responsible.

5. The provisions of this section relating to the care of venereal diseases shall not apply to municipalities where a satisfactory clinic is reasonably available.

§ 324. Local health officer; general powers and duties. 1. In addition to such other duties as may be lawfully imposed upon him and subject to the provisions of this chapter and the sanitary code, every health officer shall:

(a) make an annual sanitary survey and maintain sanitary supervision over the territory within his jurisdiction;

(b) make a sanitary inspection periodically of all places of public assemblage, and report thereon to those responsible for the maintenance of such places of public assemblage;

(c) promote the spread of information as to the causes, nature and prevention of prevalent diseases, and the preservation and improvement of health;

(d) take such steps as may be necessary to secure prompt and full reports by physicians of reportable diseases and prompt and complete registration of births and deaths;

(e) enforce within his jurisdiction the provisions of this chapter and the sanitary code; and,

(f) attend conferences called by the commissioner or his authorized representatives.

2. The health officer may employ such persons as shall be necessary to enable him to carry into effect the orders and regulations of the board of health and the provisions of this chapter and of the sanitary code, and fix their compensation within the limits of the appropriation therefor.

3. A health officer appointed for two or more towns or villages shall have and exercise in each such town or village all the rights, powers, duties and obligations conferred and imposed by law upon a health officer therein, in the same manner as though appointed separately,

rather than jointly, by the local boards of health for each such town or village.

§ 325. Local health officer; practice of medicine prohibited; certain cities. In cities of more than fifty thousand population according to the latest federal or state census or enumeration, the local health officer hereafter appointed shall devote his entire time to the duties of his office and shall not engage in the private practice of medicine.

§ 326. Local health officer; temporary or acting; appointment; compensation; powers. 1. (a) A health officer with the consent of the board of health in a town or village, and with the consent of the board or official having power to appoint a health officer in a city, may appoint a person who meets the qualifications contained in the sanitary code to act as health officer during his temporary absence or incapacity on account of illness or other cause for a period not exceeding three months.

(b) In the event that the health officer fails to, or is physically incapable of appointing a qualified person to act as health officer during his temporary absence or incapacity, then the board of health in a town or village or the board or official having power to appoint a health officer in a city, shall appoint a qualified person to act as health officer during the temporary absence or incapacity of the regular health officer, for a period not exceeding three months.

(c) If any local board of health fails to appoint an acting health officer pursuant to this section then the commissioner may appoint a qualified person to serve as such health officer during the absence or incapacity of the health officer, for a period not exceeding three months.

2. The health officer, or the board of health or other official, who appoints a qualified person to act as health officer pursuant to this section, shall report immediately in writing to the department the name and address of the person so appointed.

3. An acting health officer, during the period for which he is appointed, shall have all the rights, powers and duties imposed upon the health officer by this chapter and the sanitary code.

4. The board of health in a town or village and the board or officer having authority to fix the salary of a health officer in a city may allow such compensation as it deems reasonable covering such temporary service. The appointment of an acting health officer in a case where the regular health officer shall have been appointed jointly by two or more local boards of health for two or more towns or villages shall be with the consent of the appointing local boards, and the compensation of such acting health officer shall be allowed and paid in the same manner as the fixed compensation of the regular health officer.

§ 327. Local health officer; nurses; appointment. Every health officer or other official exercising similar duties, by whatever official designation he may be known, with the approval and consent of the local board of health of his district, shall have power to employ such number of public health nurses, qualified as provided by the sanitary code, as in his judgment may be necessary within the limits of the appropriation made therefor by the municipality.

§ 328. Local health officer; nurses; duties. Subject to the provisions of this chapter and the sanitary code, public health nurses appointed pursuant to this article, shall work under the direction of the local health officer and shall perform such duties as may be assigned by him.

§ 329. Local health officer; immunity from personal liability. 1. No health officer, inspector, investigator, public health nurse, or other representative of a health officer, and no person or persons other than the county, city, village or town by which such health officer or representative thereof is employed shall be sued or held to liability for any act done or omitted by any such health officer or representative

of a health officer in good faith and with ordinary discretion on behalf or under the direction of such county, city, village or town pursuant to its regulations or ordinances, or the sanitary code, or this chapter.

2. Any person whose property may have been unjustly or illegally destroyed or injured pursuant to any order, regulation or ordinance, or action of any board of health or health officer, or representative of a health officer, for which no personal liability may exist as aforesaid, may maintain a proper action against the county, city, village or town for the recovery of proper compensation or damages. Every such suit must be brought within six months after the cause of action arose and the recovery shall be limited to the damages suffered.

TITLE III

COUNTY AND PART-COUNTY HEALTH DISTRICTS

Section 340. County or part-county health districts; establishment.

341. County or part-county health districts; local health districts within; villages in two counties.

342. County or part-county health districts; withdrawal of a city.

343. County or part-county boards of health; organization; appointment.

344. County or part-county boards of health; terms of office; vacancies.

345. County or part-county boards of health; compensation and expenses of members.

346. County or part-county boards of health; general expenses.

347. County or part-county boards of health; powers and duties; rules and regulations.

348. County or part-county health districts; sanitary codes; violations and penalties.

349. County or part-county boards of health; other health functions; hospitals and laboratories.

350. County or part-county boards of health; officers.

351. County or part-county health commissioner, public health director or county health director; appointment;

compensation.

352. County or part-county health commissioners; powers and duties.

353. Deputy county or part-county health commissioners; assistants and employees; appointment.

354. County or part-county health districts; removal of deputies, assistants and health officers.

355. County or part-county health districts; dissolution.

356. Certain counties; legislative bodies constituted boards of health; county health directors; nurses designated as school nurses.

357. Certain counties; health services advisory boards.

§ 340. County or part-county health districts; establishment. 1. (a)

The board of supervisors of any county, with the approval of the commissioner shall have power to establish a county or part-county health district and in such event shall appoint a board of health for such county or part-county health district. No city or any part thereof shall be included as a part of any such health district unless the mayor and a majority of the common council of such city or the officials exercising similar powers shall have consented thereto and, in respect of cities having a population of fifty thousand or more, according to the last preceding federal or state census or enumeration, unless a majority of the supervisors representing that part of the county outside such city shall have consented thereto.

(b) Notwithstanding the provisions of this subdivision or any other general, special or local law to the contrary, and except as provided in the provisions of article thirteen-E of this chapter, a board of health of a county health district, if there be one, shall have sole jurisdiction to enforce the provisions of article thirteen-E of this chapter on a county-wide basis.

2. In a county containing one or more cities having a population of fifty thousand or more, according to the last preceding federal or state census or enumeration which are not to be included in a county or part-county health district, a majority of the supervisors representing

that part of the county outside such city or cities may petition the board of supervisors to establish such part of the county as a part-county health district and, upon receiving such petition, the board of supervisors shall forthwith file a certified copy of such petition with the commissioner.

3. Whenever the provisions of this section shall have been proposed to be adopted in any county, and proceedings have been taken to establish a county or part-county health district within any such county, the board of supervisors shall notify the commissioner in writing of the proposed establishment of such county or part-county health district, and in such notice shall state the extent of the territory intended to be included within such district. The consent of the commissioner to the establishment of any such health district shall be evidenced by a certificate, setting forth the approval of the commissioner to the establishment of such health district. Such certificate shall be filed with the clerk of the board of supervisors.

§ 341. County or part-county health districts; local health districts within; villages in two counties. 1. Local health districts within the area of any county or part-county health district shall continue to exist as subdivisions of such health district, and the local boards of health shall continue to exist and to retain their powers and duties subject to the rulings and regulations of the board of health of the county or part-county health district, and may continue to appoint local health officers for such local health districts as provided by law.

2. If a county or part-county health district as heretofore or hereafter established by a board of supervisors shall by its terms contain a portion of any village which lies partly within said county and partly within some other county, said village, without regard to population, shall continue its local district organization in the same manner as before, in which case the health officer of the village acting within the county or part-county health district shall be a deputy of the county health commissioner with reference to acts performed within said county or part-county health district. Provided, however, said

village may, by resolution of the village board, limit the local health district to that portion of the village lying in the county outside of the county or part-county health district, in which event the compensation of the local health officer shall be based upon the number of inhabitants in the reduced village health district, and the residents of that portion of the village lying within the county or part-county health district shall not be taxed by the village for the maintenance of such reduced local health district.

3. The governing authorities of any city, village or town or the governing authorities of the cities, villages or towns within a consolidated health district may abolish such city, village, town or consolidated health district as a local health district, whereupon all the powers and duties of the local board of health of such local health district shall devolve upon the board of health of the county or part-county health district and all the powers and duties of the local health officer of such local health district shall devolve upon the county health commissioner.

4. The governing authorities of a town or village, the local board of health of which has been abolished pursuant to the provisions of this section, when authorized by a proposition submitted and adopted in the manner provided by law, may employ a public health nurse or public health nurses, qualified as provided in the sanitary code, and make the necessary appropriation therefor. Such public health nurse, or nurses, shall work under the direction of the county health commissioner.

5. Where the local health district within the area of any county or part county health district is a town in which there are one or more incorporated villages and the local board of health is a town board, appropriations made by the town board for the purposes stated in subdivisions one and four of this section shall be a charge upon the taxable property of that part of the town outside of any incorporated village.

If a proposition is submitted as provided in subdivision four of this section for the employment of public health nurses in a town in which

there are incorporated villages which constitute a local health district, only such persons who are electors and owners of record of property in the town outside of incorporated villages shall be entitled to vote upon such a proposition.

§ 342. County or part-county health districts; withdrawal of a city.

1. The governing authorities of any city which has consented to be included in a county or part-county health district, may, at any time after three years shall have elapsed since such city has been included in such health district, by resolution adopted by said authorities, provide for the withdrawal of such city from the county or part-county health district.

2. Before such action for the withdrawal of a city from a county or part-county health district is taken an opportunity shall be given for a public hearing before such governing authorities. Public notice shall be given and the board of health of the county or part-county health district shall be notified in writing, at least thirty days in advance, of the time and place of such hearing.

3. The withdrawal of a city from a county or part-county health district, shall become effective at a time to be stated in the resolution adopted by the governing authorities of the city pursuant to the provisions of this section, which said time shall be not less than thirty days from the date of the adoption of said resolution. Upon the date when such resolution shall become effective, the local health district of such city shall be reinstated and it shall have all the powers of a local health district as though such city had not been included in the county or part-county health district pursuant to the provisions of this article.

§ 343. County or part-county boards of health; organization; appointment. 1. The board of health of a county or part-county health district shall consist of seven members, one of whom shall be a member of the board of supervisors, selected by the board of supervisors, and

at least one of whom shall be a physician licensed to practice in the state of New York, and two of whom shall be a physician, nurse practitioner, physician assistant or any combination thereof licensed to practice in the state of New York, and in addition thereto, each city which becomes a part of the county or part-county health district shall be entitled to one additional representative member on the board of health.

2. The members of the board of health of a county or part-county health district shall be residents of the health district or a resident of a contiguous county who has a background in a health-related field and performs other substantial work within the health district associated with their health-related background.

3. (a) The members of the board of health shall be appointed by the board of supervisors.

(b) The county medical society of the county in which a county or part-county health district is established may submit to the board of supervisors a list of physicians from which the board of supervisors may choose the medical members of the board of health.

(c) The additional city representative members of the board of health shall each be appointed by the board of supervisors from a list of three persons submitted by the mayor or other administrative head of such city. Such city representative members so appointed shall have all the powers and duties conferred upon other members of said board.

§ 344. County or part-county boards of health; terms of office; vacancies. 1. The term of office of each appointive member of the board of health of a county or part-county health district, including the additional city representative members shall be six years, and the term of one of the members shall expire annually; except that the term of office of the representative member of the board of supervisors shall be for such lesser period as may be required in the event that he does not continue as a member of the board of supervisors.

2. Upon the establishment of a new county or part-county health

district, the first appointments shall be made for the respective terms of six, five, four, three, two and one years.

3. Vacancies shall be filled by appointment for the unexpired terms.

§ 345. County or part-county boards of health; compensation and expenses of members. The members of the board of health of a county or part-county health district shall receive for attendance at meetings of the board, and, when authorized by the president of the board, within appropriations made therefor, for meetings of standing committees, a per diem compensation which shall be fixed by the board of supervisors, and in addition thereto, they shall be allowed actual and necessary traveling expenses, to be audited and paid in the same manner as other expenses of such board of health.

§ 346. County or part-county boards of health; general expenses. 1. In counties having a county auditor or county comptroller, all charges and other expenses of a county or part-county health district shall be audited and paid in the same manner as other charges against the county. In counties that do not have a county auditor or county comptroller, all accounts, charges, claims and demands of such health district shall be presented to and audited by the board of health of said district and paid by the county treasurer upon warrants of the said board of health within the limits of the appropriation made therefor.

2. The board of health of a county or part-county health district shall submit annually in the manner prescribed by and on or before the date fixed by or pursuant to law, an itemized estimate of the revenues and expenditures of such health district, for the ensuing fiscal year. The board of supervisors shall levy a tax upon the taxable property within the county or part-county health district, to the extent necessary to provide moneys to meet appropriations for such health district. The board of supervisors may appropriate moneys in the manner provided by law for any items of expense of the county or part-county health district which may in any degree tend to promote the efficiency

of the administration of the provisions of this chapter and the regulations adopted pursuant to the authority thereof.

§ 347. County or part-county boards of health; powers and duties; rules and regulations. 1. Upon the establishment of a board of health for a county or part-county health district as provided in this article, it shall exercise all the powers and perform all duties of local boards of health as provided in this chapter, and such board of health may formulate, promulgate, adopt and publish rules, regulations, orders and directions for the security of life and health in the health district which shall not be inconsistent with the provisions of this chapter and the sanitary code. Such rules, regulations, orders and directions shall be known as the sanitary code of such district.

a. Every rule, regulation, order and direction adopted by a board of health or a county officer or body exercising the rule-making functions of a board of health shall state the date on which it takes effect and a copy thereof signed by the county health commissioner or his deputy or such county officer or the elective or appointive chief executive officer of such county body exercising the rule-making functions of a board of health shall be filed as a public record in the department, in the county or part-county department of health and in the office of the county clerk and shall be published in such manner as the board of health or such county officer or body exercising the rule-making functions of a board of health may from time to time determine. No such rule, regulation, order or direction shall be effective prior to filing as a public record in the department.

b. The county health commissioner or his deputy shall furnish certified copies of the sanitary code of the health district and its amendments for a fee of one dollar.

c. Nothing herein contained shall be construed to restrict the power of any county, city, town or village to adopt and enforce additional ordinances or enforce existing ordinances relating to health and sanitation provided that such ordinances are not inconsistent with the

provisions of this chapter or the sanitary code.

2. The board of health of a county or part-county health district is hereby authorized to enter into contracts with one or more counties for mutual aid in the delivery of health services, including but not limited to public health emergency responses such as disease surveillance, mass immunization programs, mass antibiotic distribution, and handling of mass casualties, provided approval of such contracts by the legislative body of each county and of the commissioner is obtained. Each county or part-county health district shall be liable for acts or omissions of its employees or agents when acting pursuant to such a contract in the same manner and to the same extent as if such acts or omissions occurred within the county or part-county health district; and such employees or agents shall have immunities and privileges for their acts or omissions when acting pursuant to such a contract in the same manner and to the same extent as if such acts or omissions occurred within the county or part-county health district; except that such a contract may apportion liability otherwise between or among the county or part-county health districts.

3. Except as provided in the provisions of article thirteen-E of this chapter, a board of health of a county health district shall exercise all the powers and perform all duties relative to the enforcement of article thirteen-E of this chapter pursuant to rules and regulations promulgated by the commissioner.

§ 348. County or part-county health districts; sanitary codes; violations and penalties. 1. The provisions of the sanitary code of a county or part-county health district shall have the force and effect of law.

2. Any non-compliance or non-conformance with any provision of such sanitary code or of a rule or regulation, duly made thereunder shall constitute a violation punishable on conviction for a first offense by a fine of not more than two hundred fifty dollars or by imprisonment for not more than fifteen days or by both such fine and imprisonment; and

for a second or subsequent offense by a fine not exceeding five hundred dollars or by imprisonment for not exceeding fifteen days, or both.

3. Certified copies of the sanitary code of a county or part-county health district shall be received in evidence in all courts and proceedings in the state.

§ 349. County or part-county boards of health; other health functions; hospitals and laboratories. In any county in which a county health district has been or is hereafter established, the boundaries of which are coterminous with the county, the board of supervisors shall have power to abolish the board of managers of the county tuberculosis hospital, or of the county public general hospital, or of the county laboratory, and, if so abolished, shall confer all the powers and duties of any or all of such boards of managers upon the county board of health.

§ 350. County or part-county boards of health; officers. The board of health of a county or part-county health district shall elect annually one of its members as president and another as vice-president. The board of health may designate the county health commissioner to act as its secretary without extra compensation.

§ 351. County or part-county health commissioner, public health director or county health director; appointment; compensation. 1. The board of health of each county and part-county health district or other body having the powers and duties of a board of health of a county or part-county health district or the county executive in those counties where the county charter provides that said commissioner is to be appointed by the county executive shall appoint a county health commissioner, county health director or, when authorized under the state sanitary code, public health director; except, however,

(a) that the boards of health of not more than three county or part-county health districts or other bodies having the powers and

duties of a board of health of a county or part-county health district may appoint the same person to serve as county health commissioner, county health director or, when authorized by the state sanitary code, public health director for said health districts, if the total population of health districts is not in excess of one hundred fifty thousand according to the latest federal decennial census, provided the approval of the commissioner is obtained; or

(b) the board of health or other body having the powers and duties of a board of health of a county or part-county health district of any county health district with a population of less than thirty-five thousand according to the latest federal decennial census may appoint the same person employed by a contiguous county or part-county health district to serve as county health commissioner, county health director or, when authorized by the state sanitary code, public health director without regard to the total population of both health districts, provided the approval of the commissioner is obtained.

The commissioner shall periodically review his or her determination to ensure such employment of the same county health director, director of public health or county health commissioner continues to serve the interest of public health and may terminate his or her approval at his or her discretion.

2. If the commissioner has approved the appointment of the same person to serve as the county commissioner of health or public health director of more than one county or part-county health district pursuant to subdivision one of this section, then during the continuation of such approval the commissioner may also authorize the same members to be appointed to the board of health of each respective health district, notwithstanding their residency in the other county.

3. Any boards of health or other bodies having the powers and duties of a board of health of a county or part-county health district having the same members shall annually submit such information and reports regarding the effect of such employment on administration of the respective health districts and the provision of public health services as the commissioner may require. The commissioner shall use such

information in determining whether such common membership continues to serve the interest of public health.

4. The county health commissioner or public health director shall possess such qualifications for office as are prescribed in the sanitary code.

5. The county health commissioner or public health director shall serve for a term of six years and shall not be removed during the term for which he or she shall have been appointed, except upon written charges after a hearing and upon notice.

6. The county health commissioner or public health director shall receive such compensation as may be fixed by the board of supervisors or, if the commissioner's approval has been obtained for the employment of the same person as the county health commissioner or public health director pursuant to subdivision one of this section, by the boards of supervisors.

§ 352. County or part-county health commissioners; powers and duties.

1. Every county health commissioner shall devote his entire time to the duties of his office except that in a county operating as a county health district, the boundaries of which are co-terminous with the county, he may, with the approval of the commissioner, be appointed superintendent of the county general hospital and further excepted, that in a county or part-county health district, he may, with the approval of the commissioner, be appointed medical consultant to any county or other local governmental agency within the county or part-county health district.

2. The county health commissioner shall, within his district, exercise general supervision and control of the medical treatment of patients in the institutions, public health centers and clinics operated by the health district and possess all the powers conferred upon and perform all the duties required of local health officers.

3. (a) The county health commissioner, within his district and with the approval of the county board of health, or the county manager or county executive in those counties having an optional or alternative form of county government, and with the approval of the state commissioner of health, may enter into contracts

(1) with corporations duly licensed in the state of New York to transact the business of accident and health insurance to provide to sick and disabled persons insured by them such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by them;

(2) with hospital service corporations organized and operating in accordance with article forty-three of the insurance law to provide to their subscribers nursing service and such other paramedical services as would have been available in a hospital (excluding physicians' services) at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services;

(3) with any municipal corporation or local, state or federal agency to provide such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by sick and disabled persons;

(4) with medical expense indemnity corporations organized and operating in accordance with article forty-three of the insurance law to provide their subscribers with such home care, including nursing and other paramedical services as may be needed by them at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services; and

(5) with any non-profit corporation, agency or association established for the purpose of improvement of health services, or for the purpose of providing home care for sick and disabled persons, including nursing and other paramedical services (excluding physicians' services) as may be needed by such persons.

(6) with any dentist, physician or group of physicians, without public bidding, for the rental or use of a portion of a clinic or public health center and its equipment and furnishings provided, however, that any such dentist, physician or group of physicians shall render such care and treatment as shall be necessary or possible under the circumstances to any person found eligible for emergency treatment including those

found in an unconscious, seriously ill or wounded condition and to any person eligible for medical assistance pursuant to section three hundred sixty-six of the social services law.

(b) such county commissioner, manager or executive, as the case may be, shall establish the fees to be charged for such services to be rendered pursuant to such contracts, collect such fees and pay the same over to the fiscal officer of the county in the manner provided by law. No contract made in accordance with the provisions of subdivision (a) of this section shall require payment for such services to an insured or subscriber at a rate in excess of the charge for the same service, if any, provided to a person afflicted with a similar disease or condition who is neither insured nor a subscriber.

4. The county or part-county health commissioner within his district and with the approval of the county or part-county board of health, or the county manager or county executive in those counties having an optional or alternate form of county government and with the approval of the state commissioner of health may establish and collect fees from a patient or a person or private or public agency responsible for his care for services rendered to patients in the institutions, public health centers and clinics operated by the health district and for nursing and paramedical services (excluding physicians' services) rendered to people sick at home. Fees so collected shall be paid to the fiscal officer of the county in the manner provided by law.

5. The county or part-county health commissioner may in his discretion, in proper cases, where substantial justice will best be served thereby, waive the collection of all, or any portion of, such fees or compromise any portion of such fees. Such waiver or compromise shall be made only upon prior approval of the county or part-county board of health, or the county manager or county executive in those counties having an optional or alternate form of county government, when it is deemed to be in the best interests of the county.

6. The county or part-county health commissioner, the public health director, the New York city commissioner of health or the county manager or county executive in those counties having an optional or alternate

form of county government, may contract with a private collection agency for the collection of overdue claims and obligations with respect to fees charged for physician, dentist, nursing, paramedical, therapist, laboratory and home health services and medical supplies and equipment or other health-related services provided by, on behalf of, or at the request of the county or part-county health district or health department.

§ 353. Deputy county or part-county health commissioners; assistants and employees; appointment. 1. Local health officers who continue to hold office after the establishment of a county or part-county health district, pursuant to the provisions of this article, shall be deputies of the county health commissioner, who may require any such local health officer to perform within his jurisdiction any of the duties required of local health officers.

2. The county health commissioner may appoint with the approval of the board of health such additional deputies, assistant deputies and other employees as may be required to fulfill the purposes of this article in the health district and as may be authorized by the board of supervisors pursuant to the provisions of section four hundred one of the county law. Such deputies and assistant deputies and other employees shall have the qualifications prescribed in the sanitary code.

3. The county health commissioner may designate in writing a deputy, qualified in accordance with the provisions of the sanitary code, to whom shall be delegated all the powers and duties of the county health commissioner when such commissioner is unable to act by reason of absence or disability.

§ 354. County or part-county health districts; removal of deputies, assistants and health officers. 1. The board of health of a county or part-county health district shall have power to remove the health officer of any local health district included within such county or part-county health district or any deputy or assistant deputy of the

county health commissioner for cause, upon written charges, and after such health officer or deputy, or assistant deputy, after due notice, has been given an opportunity to be heard.

2. The proceedings in connection with such removal shall be subject to review by the commissioner, who within thirty days of the receipt of an order of the board of health removing such health officer, may revoke such order whereupon the order of removal shall be void.

§ 355. County or part-county health districts; dissolution. 1. The board of supervisors of any county in which a county or part-county health district has been or may be established, with the consent of the supervisors representing that part of a county included in the district in respect to a part-county health district, may abolish such district at any time after three years shall have elapsed following its establishment, provided, however, that before such action may be taken an opportunity shall be given for a public hearing. Public notice shall be given and the commissioner shall be notified in writing, at least thirty days in advance, of the time and place of such hearing.

2. The action of the board of supervisors abolishing a health district pursuant to the provisions of this section shall become effective thirty days after the adoption of the resolution to abolish such health district, and at the end of such period the terms of office of the members of the board of health and of the county health commissioner shall terminate.

§ 356. Certain counties; legislative bodies constituted boards of health; county health directors; nurses designated as school nurses. 1. The legislative body of each county having a population of less than one hundred fifty thousand according to the nineteen hundred seventy federal decennial census or the legislative body of any county whose population shall be less than one hundred fifty thousand under any future federal decennial census, except a county in which a county or part-county health district has been established under this article or a county

having a county charter, optional or alternative form of government, shall constitute the board of health of such county and shall have all the powers and duties of a board of health of a county or part-county health district including the power to appoint a full-time or part-time county health director. The county health director may serve as director of the children and youth with special health care needs support services program and may employ such persons as shall be necessary to enable the county health director to carry into effect the orders and regulations of the board of health and the provisions of this chapter and of the sanitary code, and fix their compensation within the limits of the appropriation therefor. The members of a legislative body shall not receive additional compensation by reason of serving as members of a board of health. The county health director, so appointed, shall have all the powers and duties prescribed in section three hundred fifty-two of this title.

2. (a) With the approval of the county health director, the trustee or board of trustees of any common school district or the board of education of any union free school district or central school district within the county, may designate any nurse employed as provided in this section as a school nurse to perform, in addition to her other duties, the duties of a school nurse for any school or schools under such respective trustee, board of trustees or board of education.

(b) Any nurse so designated shall perform her duties as school nurse under the direction of the school medical inspector and the appropriate school authorities and under the provisions of the education law and the regulations prescribed pursuant thereto.

§ 357. Certain counties; health services advisory boards. 1. In a county wherein the legislative body constitutes the board of health of such county under and pursuant to the provisions of section three hundred fifty-six of this title, the county shall provide for the appointment by the board of health of a health services advisory board consisting of nine members. One member shall be a physician licensed to practice in the state of New York and one member shall be a physician, nurse practitioner, or physician assistant licensed to practice in the

state of New York. The remaining members of the board shall be known as public members and shall be selected on the basis of their interest and knowledge regarding the health needs, resources and facilities of the community.

2. The health services advisory board shall advise the county health director with respect to the discharge of his powers, responsibilities and duties.

3. A person may hold other public office or employment while serving as a member of a health services advisory board.

4. The members of a health services advisory board shall have fixed terms of four years except that three of the initial appointments shall be for two years and three shall be for three years. A term shall be deemed to run from the first day of the year in which the appointment is made. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person may serve as a member for more than two terms consecutively.

5. Board members shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

6. Two or more such counties may agree to form a conjoined health services advisory board. Each county shall be entitled to appoint members in accordance with the provisions of subdivision one or may appoint such proportion of the total membership so computed as is mutually agreed upon by the participating counties.

7. Board members shall be residents of the county or a resident of a contiguous county who has a background in a health-related field and performs other substantial work within the county associated with their health-related background.

TITLE IV **CERTAIN CITIES**

- Section 360. Certain cities; department of public health; establishment.
361. Certain cities; commissioner of health and health officer; appointment and qualifications.
362. Certain cities; term of office of commissioner and health officer; removal.
363. Certain cities; appointment of deputy commissioners and others; removal.
364. Certain cities; compensation of commissioner and others.
365. Certain cities; undertakings required of health officers.
366. Certain cities; commissioner of health and health officer; powers and duties.
367. Certain cities; deputy commissioners; powers.
368. Certain cities; advisory board; appointment; compensation.
369. Certain cities; appointment of experts; compensation.
370. Certain cities; duty in case of peril to public health.
371. Certain cities; sanitary codes.
372. Certain cities; existing regulations and sanitary codes.
373. Certain cities; sanitary codes; violations and penalties.
374. Certain cities; appeals from orders of commissioner of health or health officers.
375. Certain cities; actions to restrain nuisances.
376. Certain cities; enforcement.
377. Certain cities; license fees.
378. Certain cities; contracts and fees for health services.

§ 360. Certain cities; department of public health; establishment. 1. The common council or similar legislative body of each city having a population of less than one hundred seventy-five thousand which has not by special law established a department of health, is hereby authorized and empowered by ordinance to abolish its board of health and in its place to create, establish and maintain a department of public health.

2. The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand, and the health officer in cities having a population of less than fifty thousand shall be the head of such department.

§ 361. Certain cities; commissioner of health and health officer; appointment and qualifications. 1. The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand shall be appointed by the mayor, and the health officer in cities having a population of less than fifty thousand shall be appointed by the same official or body who or which by charter is authorized to appoint the heads of city departments.

2. No person shall be eligible to appointment as commissioner of health or health officer unless he shall be a physician and surgeon duly licensed to practice under the laws of this state and who has practiced as such, or has been engaged in public health work for at least five years and who shall comply with the qualifications therefor prescribed by the public health council in the sanitary code, provided, however, that a physician who has received the degree of doctor of public health in a course in any institution of learning recognized by the University of the State of New York shall be eligible for appointment as health officer in cities having a population of less than fifty thousand.

§ 362. Certain cities; term of office of commissioner and health officer; removal. 1. The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand, and the health officer in cities having a population of less than fifty thousand, respectively, shall serve for a term of four years.

2. (a) The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand and the health officer in cities having a population of less than fifty thousand, shall not be removed by the official or body appointing him during the term for which he shall have been appointed other than for inefficiency, neglect of duty or misconduct in office, upon written charges and after an opportunity of being publicly heard in his defense.

(b) A copy of such charges shall be personally served upon such commissioner of health in cities having a population of fifty thousand

to one hundred seventy-five thousand or health officer in cities having a population of less than fifty thousand and he shall be given not less than five days' notice of the time and place of the hearing.

§ 363. Certain cities; appointment of deputy commissioners and others; removal. 1. The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand may appoint and at pleasure remove a deputy commissioner of health who shall be qualified as prescribed in the sanitary code.

2. The commissioner of health in cities having a population of fifty thousand to one hundred seventy-five thousand or health officer in cities having a population of less than fifty thousand shall appoint such subordinates as shall be prescribed by the board of estimate and apportionment or other board or authority in such cities which is by charter authorized to designate the number of employees.

§ 364. Certain cities; compensation of commissioner and others. In cities having a population of less than one hundred seventy-five thousand, the salary of the commissioner of health, deputy commissioner of health, health officer and all subordinates shall be fixed by the board of estimate and apportionment, or by the board or authority authorized by charter to fix salaries.

§ 365. Certain cities; undertakings required of health officers. Before entering upon the discharge of the duties of their respective offices, the commissioner of health, deputy commissioner of health or health officer in cities having a population of less than one hundred seventy-five thousand, shall each execute and file with the city clerk such official undertakings as the common council or similar legislative authority shall prescribe.

§ 366. Certain cities; commissioner of health and health officer;

powers and duties. 1. The commissioner of health or the health officer in cities having a population of less than one hundred seventy-five thousand shall:

(a) exercise all the powers and be charged with all the duties now or hereafter conferred upon or required of local boards of health or local health officers by the laws of this state so far as the same pertain to cities, except as limited or extended by the provisions of this article; and,

(b) possess such powers and perform such duties as may be prescribed by ordinance of the common council or similar legislative authority by this chapter or otherwise by law.

§ 367. Certain cities; deputy commissioners; powers. In case of the absence or disability of the commissioner of health or health officer in cities having a population of less than one hundred seventy-five thousand, or of any vacancy in the office, the deputy commissioner of health, when there is one, shall discharge the duties of the office until the commissioner of health or health officer returns, his disability ceases or the vacancy is filled.

§ 368. Certain cities; advisory board; appointment; compensation. 1. In cities having a population of less than one hundred seventy-five thousand, the mayor may appoint, and at his pleasure remove five resident and practicing physicians of the city who shall act as an advisory board to the mayor or commissioner of health or health officer upon matters pertaining to public health whenever requested by such mayor, commissioner, or health officer.

2. The members of such advisory board shall serve without compensation.

§ 369. Certain cities; appointment of experts; compensation. The commissioner of health or health officer in cities having a population of less than one hundred seventy-five thousand, with the written consent

of the mayor and subject to the approval of the board of estimate and apportionment or other board having similar powers in such cities and the common council or similar legislative authority in cities having no boards of estimate and apportionment or authorities with similar powers may temporarily employ such health and sanitary experts as may be necessary at a compensation fixed by the board of estimate and apportionment or other authority having power by charter to fix salaries of appointive officials.

§ 370. Certain cities; duty in case of peril to public health. 1. In case of great and imminent peril to the public health of the city, it shall be the duty of the commissioner of health or health officer in cities having a population of less than one hundred seventy-five thousand, with the approval and consent of the common council or similar legislative authority if it be practicable to convene that authority for prompt action, or if not, when approved by the board of estimate and apportionment or authority of similar powers, to take such measures and to do, order or cause to be done such acts and to make such extraordinary expenditures, in excess of the sum appropriated to the department of health, as provided by law, for the preservation and protection of the public health of such city, as he may deem necessary and proper.

2. Such peril to public health shall be deemed to exist only when and for such period as the commissioner of health and board of estimate and apportionment in cities having a population of fifty thousand to one hundred seventy-five thousand, and in cities having a population of less than fifty thousand, the health officer and the board of estimate and apportionment or authority having similar power and the common council or similar legislative authority in a city having no board of estimate and apportionment or authority with similar power, shall determine.

§ 371. Certain cities; sanitary codes. 1. The commissioner of health in cities having a population of less than one hundred seventy-five thousand or the health officer in cities having a population of less

than fifty thousand shall:

(a) formulate, adopt, promulgate and enforce complete rules, regulations, orders and directions for the security of life and health in the city, which shall not be inconsistent with the sanitary code; and

(b) in conjunction with the board of examining plumbers, formulate, adopt and promulgate rules and regulations for plumbing and drainage which shall govern the same.

2. The rules, regulations, orders and directions promulgated and adopted pursuant to the provisions of this section shall be known as the sanitary code of the city.

3. Before such rules and regulations shall take effect they shall be approved in writing by the mayor in cities having a population of fifty thousand to one hundred seventy-five thousand and by the common council or similar legislative authority in cities having a population of less than fifty thousand. After such approval the sanitary code of the city shall be published in such manner as the legislative authority shall prescribe.

4. The sanitary code of such cities may embrace all matters and subjects to which and so far as the jurisdiction, power and authority of the department of health of the city extends not inconsistent with the constitution or laws of the state, and may be revised, altered, amended or annulled from time to time by the commissioner of health or health officer of the city with the approval of the mayor in cities having a population of fifty thousand to one hundred seventy-five thousand and the common council or similar legislative authority in cities having a population of less than fifty thousand. The provisions thereof shall be binding and in full force and effect in such city.

§ 372. Certain cities; existing regulations and sanitary codes. The existing sanitary codes of cities having a population of less than one hundred seventy-five thousand, and all rules, regulations and special directions heretofore duly formulated, adopted and promulgated by the commissioner of public safety, the board of health or the health

officer, shall continue in full force and effect, except as the same may be revised, altered, amended or annulled from time to time as provided by law.

§ 373. Certain cities; sanitary codes; violations and penalties. 1.

The sanitary code of a city having a population of less than one hundred seventy-five thousand may provide for specific penalties for any violation thereof not exceeding one thousand dollars for each offense.

2. Except where specific penalty is so provided for, any person who violates or who fails to comply with any provision of the sanitary code, or of any rule, regulation, order or special direction duly made thereunder or authorized by this article, shall forfeit and pay to the city a penalty not to exceed one thousand dollars for each and every offense.

3. All suits and proceedings authorized by this article or to recover any penalty provided for in the sanitary code, or by this article, shall be brought by and in the name of the city, but no fees or costs shall be demanded or recovered from the commissioner of health or health officer of the city, or any officer thereof, in such suit or proceeding or action.

4. Any person who shall wilfully violate, neglect or refuse to comply with any provision or requirement of this article, or of any provision of the sanitary code of a city, or of any rule, regulation, order or special direction duly made thereunder, or authorized by this article shall in addition to the penalty or penalties therein or herein prescribed also be guilty of a misdemeanor.

§ 374. Certain cities; appeals from orders of commissioner of health or health officers. 1. Any person aggrieved by an order, decision or direction of the commissioner of health or health officer of a city having a population of less than one hundred seventy-five thousand, may appeal therefrom to the official or authority which appoints the head of

the department of health of such city, who or which may affirm, reverse or modify the order, decision or direction appealed from.

2. Such appeal may be made by serving on the said commissioner of health or health officer a written notice of appeal within two days, Sundays and legal holidays excepted, or within such further time as shall be allowed by the official or authority having power to hear the appeal after the appellant received notice of the order, decision or direction appealed from. Within two days after receiving such notice of appeal, Sundays and legal holidays excepted, the commissioner of health or health officer shall make a written return to the official or authority having power to hear the appeal of the facts and evidence on which such order, decision or direction is founded. Upon receipt of such return, or if no return be made within the time specified, the official or authority having power to hear the appeal shall forthwith proceed to hear and determine the matter. Upon such appeal the official or authority having power to hear it need not be confined to the evidence contained in the return but in his or its discretion may take additional evidence.

3. Until the decision of the appeal is made the order, decision or direction appealed from shall not be suspended unless the official or authority having power to hear the appeal by an order in writing shall so direct, which order shall be filed forthwith in the office of the commissioner of health or health officer of the city.

4. In case of failure to sustain the appeal the official or authority having power to hear the appeal may in his or its discretion impose costs not exceeding ten dollars upon the appellant.

§ 375. Certain cities; actions to restrain nuisances. The commissioner of health or health officer of a city having a population of less than one hundred seventy-five thousand, is authorized, by and with the advice and consent of the corporation counsel or city attorney, in the name of the city to maintain actions to restrain the threatened performance or the continued performance of any act contrary to his orders, directions,

decisions or ordinances, and to restrain and abate nuisances, and for the purpose of obtaining a temporary injunction in any such action no undertaking shall be required.

§ 376. Certain cities; enforcement. The head of the police department shall whenever requested in writing by the commissioner of health or health officer in cities having a population of less than one hundred seventy-five thousand, with the approval of the mayor, detail such number of regular police officers as shall be specified in such request who shall while so detailed serve under the direction of the commissioner of health or health officer.

§ 377. Certain cities; license fees. No license or permit shall be issued to any person or for any purpose subject to the jurisdiction or control of the commissioner of health or health officer of a city having a population of less than one hundred seventy-five thousand, except on the written approval of the department of health of such city and the payment thereof of the fee to be fixed by such commissioner or health officer. The amount of such fee to be paid shall be fixed by a general regulation made by such commissioner or health officer for each class of licenses or permits issued. Such license or permit shall be issued and such license fee shall be received by the official designated in the ordinance creating the department of health.

§ 378. Certain cities; contracts and fees for health services. (a) In cities having a population of less than one hundred and seventy-five thousand and in those cities which have by special law established a department of health, the commissioner of health or health officer, with the consent and approval of the mayor and the board of estimate and apportionment or other board having similar power in such cities and the common council or similar legislative authority in cities having no such boards, may enter into contracts

(1) with corporations duly licensed in the state of New York to transact the business of accident and health insurance to provide to

sick and disabled persons insured by them such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by them;

(2) with hospital service corporations organized and operating in accordance with article forty-three of the insurance law to provide to their subscribers nursing service and such other paramedical services as would have been available in a hospital (excluding physicians' services) at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services;

(3) with any municipal corporation or local, state or federal agency to provide such home care, including nursing and other paramedical services (excluding physicians' services) as may be needed by sick and disabled persons;

(4) with medical expense indemnity corporations organized and operating in accordance with article forty-three of the insurance law to provide their subscribers with such home care, including nursing and other paramedical services, as may be needed by them at rates which shall prior to payment be approved as to reasonableness by the superintendent of financial services; and

(5) with any non-profit corporation, agency or association established for the purpose of improvement of health services, or for the purpose of providing home care for sick and disabled persons, including nursing and other paramedical services (excluding physicians' services) as may be needed by such persons.

(6) with any dentist, physician or group of physicians, without public bidding, for the rental or use of a portion of a clinic or public health center and its equipment and furnishings provided, however, that any such dentist, physician or group of physicians shall render such care and treatment as shall be necessary or possible under the circumstances to any person found eligible for emergency treatment including those found in an unconscious, seriously ill or wounded condition and to any person eligible for medical assistance pursuant to section three hundred sixty-six of the social services law.

(b) Such commissioner of health or health officer shall establish the fees to be charged for such services to be rendered pursuant to such contracts, collect such fees and pay the same over to the fiscal officer of the city in the manner provided by law. No contract made in

accordance with the provisions of subdivision (a) of this section shall require payment for such services to an insured or subscriber at a rate in excess of the charge for the same service, if any, provided to a person afflicted with a similar disease or condition who is neither insured nor a subscriber.

(c) The commissioner of health or health officer with the consent and approval of the mayor and the board of estimates and apportionment or other board having similar power in such cities and the common council or similar legislative authority in cities having no such boards may establish and collect fees from a patient or a person or private or public agency responsible for his care for services rendered to patients in the institutions, public health centers and clinics operated by the city and for nursing and other paramedical services (excluding physicians' services) rendered to people sick at home. Fees so collected shall be paid to the fiscal officer of the city in the manner provided by law.

(d) The commissioner of health or health officer may in his discretion, in proper cases, where substantial justice will best be served thereby, waive the collection of all, or any portion of, such fees or compromise any portion of such fees. Such waiver or compromise shall be made only upon prior approval of the mayor and the board of estimate and apportionment or other board having similar power in such cities and the common council or similar legislative authority in cities having no such boards, when it is deemed to be in the best interests of the city.

TITLE V

STATE PARK HEALTH DISTRICTS

Section 380. State park health district; establishment.

381. State park health district; board of health; membership.

382. State park health district; board of health; powers and duties.

383. State park health district; health officer; powers and duties.

§ 380. State park health district; establishment. The commissioner may in his discretion, from time to time, create health districts comprised exclusively of lands lying within the boundaries of a state park by filing in the office of the secretary of state an order defining generally the boundaries of such district or districts.

§ 381. State park health district; board of health; membership. Upon the making and filing of an order by the commissioner creating and establishing a state park health district pursuant to section three hundred eighty of this chapter, the local board of health of such district shall consist of the park commission, and ex officio, the state commissioner of health or his duly authorized representative.

§ 382. State park health district; board of health; powers and duties. The board of health of a state park health district shall have all the powers and duties of local boards of health and shall appoint a health officer qualified as provided by the sanitary code.

§ 383. State park health district; health officer; powers and duties. The health officer of a state park health district shall have all the powers and duties under the law of the state and the sanitary code which local health officers now have or hereafter shall have within their respective localities.

TITLE VI

CONSOLIDATED HEALTH DISTRICTS

- Section 390. Consolidated health district; establishment.
391. Consolidated health district; board of health; organization.
392. Consolidated health district; status of existing local boards of health.
393. Consolidated health district; board of health; terms of office.

- 394. Consolidated health district; board of health; officers.
- 395. Consolidated health district; board of health; health officer; powers and duties.
- 395-a. Designation of depository.
- 396. Consolidated health district; health officer; appointment.
- 397. Consolidated health district; appointment of attorney.
- 398. Consolidated health district; compensation of board members.
- 399. Consolidated health district; expenses.

§ 390. Consolidated health district; establishment. The commissioner, on the written request of the town board of any town and the board of trustees of any village and the common council or other like authority of any city, may combine into one health district, hereinafter referred to as a consolidated health district, any two or more of such towns, villages or cities and may on the written request of the town board of any town, board of trustees of any village or common council or other like authority of any city at any time thereafter set apart such town, village or city as a separate health district.

§ 391. Consolidated health district; board of health; organization. 1. In every consolidated health district there shall be a board of health which shall consist of the supervisor of each town, the president of the board of trustees of each village, and the mayor and the supervisors of each city included in each district, provided that if the number of members so provided for is an even number less than seven, such members shall within thirty days after such district shall have been established by the commissioner choose an additional member of such board of health to be known as the elective member, and if the number of members so provided for is more than seven such members shall meet and elect a board of health of three members for such consolidated health district.

2. A member of the board, sitting ex-officio and not as one of a new board of three elected as hereinbefore provided, who is the lawful

incumbent of more than one of the offices entitling him to membership shall have as many votes in the board as there are municipalities of the district, in which he holds such offices, and in such a case the total number of votes on the board shall be regarded as the number of members, in applying the provisions hereof relative to the choosing of an additional member or reducing the membership to a board of three.

§ 392. Consolidated health district; status of existing local boards of health. 1. When any consolidated health district is established, as provided in this article, the boards of health of the towns, villages or cities included within such district, shall thereupon cease to exist as boards of health, and all their rights, powers, duties and obligations shall thereupon be transferred to the board of health of such district.

2. When the board of health of any such consolidated health district shall have appointed a health officer therefor, the terms of office of the health officers of the towns, villages or cities included in such district shall cease, and all their rights, powers, duties and obligations shall thereupon be transferred to and imposed upon the health officer appointed for such consolidated health district.

§ 393. Consolidated health district; board of health; terms of office. 1. Of the new reduced three member board of health of a consolidated health district first elected, one member shall be elected to serve until one year from the first day of January following his election, one to serve two years, and one to serve three years from such first day of January, and until his successor has been elected and has qualified.

2. Prior to December first each year the village mayors and supervisors of the municipalities included in the consolidated health district shall meet and elect one member of the board of health who shall serve three years from the January first following and until his successor has been elected and has qualified.

3. An elective member shall serve for a term of two years from the

first day of January preceding his election and until his successor shall have been appointed, provided that if at any time the number of members of the board of health, excluding the elective member, shall become an odd number, the term of office of the elective member shall thereupon cease.

§ 394. Consolidated health district; board of health; officers. The board of health of a consolidated health district shall from time to time elect a president from among its members. The health officer of a consolidated health district shall serve as the secretary of the board of health thereof without additional remuneration therefor.

§ 395. Consolidated health district; board of health; health officer; powers and duties. Each board of health and each health officer of a consolidated health district shall have all the rights, powers, duties and obligations conferred and imposed by law upon boards of health and health officers respectively.

§ 395-a. Designation of depository. The board of health of any consolidated health district may designate by resolution one or more banks or trust companies in which the moneys paid to the president of the board as provided herein shall be deposited. Notwithstanding the provisions of section four hundred ten of the education law, in a consolidated health district in which there is but one bank or trust company, the bank or trust company so designated as depository may be one of which members of such board of health are officers, directors or stockholders. Such designation and deposit of such moneys shall release the president of the board from any liability for loss of such moneys by reason of the default or insolvency of any such depository. The board of health may require any bank or trust company so designated as a depository in which such moneys are on deposit or are to be deposited to deliver to such board a surety bond payable to the consolidated health district, executed by a surety company authorized to transact business in this state and securing to such district the payment of such

deposits; or in lieu of such a surety bond, such board may require any such bank or trust company to deposit with such board obligations of the United States of America, of the state of New York or of any county, town, city, village or school district of the state of New York as security for such moneys so deposited, but such obligations shall be subject to the approval of such board and shall be held for safekeeping at such place and under such conditions as such board may determine.

§ 396. Consolidated health district; health officer; appointment. In each consolidated health district the board of health shall appoint a health officer qualified as provided in the sanitary code.

§ 397. Consolidated health district; appointment of attorney. The board of health of a consolidated health district may employ and fix the compensation of an attorney, which shall be audited and paid in the same manner as the other expenses of the district.

§ 398. Consolidated health district; compensation of board members. 1. Members of the board of health of a consolidated health district, whether or not members of a town board or a village board of trustees, shall be allowed a per diem compensation of not more than ten dollars for each calendar day in actual attendance at a meeting of the board of health of the district, to be fixed and determined by the board of health of the district and which compensation in the case of any member shall not exceed the sum of one hundred and fifty dollars in any one year.

2. Members of the board of health of a consolidated health district shall also be allowed their actual and necessary expenses.

3. The compensation and expenses of members of the board of health of a consolidated health district shall be audited and paid in the same manner as the other expenses of the consolidated health district.

§ 399. Consolidated health district; expenses. 1. The board of health of each consolidated health district shall from time to time audit all accounts, and allow or reject all charges, claims and demands against such health district for the remuneration and expenses of the health officer, registrar or registrars, and for all other expenses lawfully incurred by said board of health or on its authority.

2. (a) Unless the board of health of such consolidated health district adopts the estimate system of payments as provided by this section they shall, prior to the annual meeting of the board of supervisors each year, make an abstract to be known as the consolidated health district abstract, of the names of all persons who have presented to them accounts to be audited, the amounts claimed by each such person and the amounts finally audited and approved by them respectively, and, if such district be wholly in one county, shall deliver such abstract to the clerk of the board of supervisors.

(b) If such consolidated health district be located in more than one county the board of health of such district shall divide the total amount of the consolidated health district abstract as audited and approved in proportion to the assessed valuation of the real property of the towns, villages or cities of such consolidated health district located in each county, with a statement of the amount due from the real property of each town, village or city of the consolidated health district in each such county on account of the expenses of such board.

(c) The board of supervisors of each such county shall levy a tax upon the real property of each town, village or city within such consolidated health district sufficient to provide for the sums audited and approved by the board of health thereof and chargeable to the real property of each town, village or city of the consolidated health district in each such county.

(d) Such sums, when collected and paid to the county treasurer of each such county, respectively, shall be paid by him to the president of the board of health and shall be disbursed by him in accordance with the abstract of claims audited and approved by such board of health, as provided by this section.

3. (a) The board of health of any consolidated health district may annually make an estimate of the expenses of such board for the ensuing calendar year and, if such district be wholly in one county, shall deliver a certified copy of such estimate to the clerk of the board of supervisors of such county prior to the annual meeting of the board preceding such year.

(b) If such consolidated health district be located in more than one county, the board of health of such district shall proportion the total amount of such estimate in the same manner as provided by this section for proportioning the expenses of such a district when audited and approved by the board, and shall deliver to the clerk of the board of supervisors of each such county a certified statement of the total estimate and the amount due from the real property of each town, village or city of the consolidated health district in each such county on account thereof.

(c) The board of supervisors of each county shall levy a tax upon the real property within such health district sufficient to provide for the portion of the amount of such estimate chargeable to the real property of each town, village or city of the consolidated health district in each such county.

(d) Such sums, when collected and paid to the county treasurer of each county respectively, shall be paid by him to the president of the board of health and shall be disbursed by the board of health in accordance with the estimates.

(e) After such estimate system has been adopted by a consolidated health district, the board of health thereof shall deduct from the estimate for the succeeding calendar year the amount, if any, remaining in the custody of such board after all of the liabilities incurred on account of the preceding estimate have been paid, before the certified statement of the total estimate and the amount due from the real property of each town, village or city of the consolidated health district in each such county is certified to the respective clerks of the boards of supervisors for collection.

4. A consolidated health district may adopt the estimate system as provided by this section, and, as provided by this section, may make and file with the clerk of the board of supervisors of the county, or if

such district be located in more than one county, with the clerk of the board of supervisors of each such county, an estimate for the remainder of the current year and for the ensuing calendar year.

ARTICLE 4

PROPERTY AND HOSPITALS IN THE DEPARTMENT OF HEALTH

Title I. General provisions (§§ 401-410).

II. Hospitals: boards of visitors (§§ 420-425).

IV. Hospitals: officers and employees (§§ 450-455).

TITLE I

GENERAL PROVISIONS

Section 401. Land; purchase or acquisition.

403. Hospitals; property; authority to acquire and to hold.

403-a. The New York state home for veterans and their dependents at Oxford.

403-b. The New York state home for veterans in the city of New York.

403-c. The New York state home for veterans in western New York.

403-d. The New York state home for veterans in the lower-Hudson Valley.

404. Hospitals; property; authority to acquire and to hold.

405. Hospitals; visitors and officers; oaths and bonds.

406. Hospitals; refunds, waivers and compromises of bills.

407. Hospitals; privileges to students.

408. Hospitals; admission of patients; in general.

409. Department of health income fund.

409-a. Department of health New York city veterans home income fund.

409-b. Distribution of surplus revenue.

409-c. Powers and duties of the commissioner; administrative and fiscal functions.

410. Hospitals; reimbursement.

§ 401. Land; purchase or acquisition. 1. The commissioner, when an appropriation therefor has been made by the legislature, may acquire any real property which he may deem necessary for any departmental purpose by purchase or acquisition pursuant to the eminent domain procedure law.

Title to any such real property shall be taken in the name of and be vested in the people of the state of New York; provided, however, that no real property shall be so acquired by purchase unless the title thereto shall be approved by the attorney general.

2. Whenever real property is to be acquired pursuant to the eminent domain procedure law the commissioner shall cause to be made by the state department of transportation an accurate acquisition map as provided in such law.

3. On the approval of such map by the commissioner, the original tracing of such map shall be filed in the main office of the department.

4. If the commissioner shall determine, prior to the filing of such map in the office of the clerk or register of the county, that changes, alterations or modifications of such map as filed in the main office of the department should be made, he or she shall, subject to the provisions of article two of the eminent domain procedure law, if applicable, direct the preparation by the department of transportation of an amended map. On the approval of such amended map by the commissioner, it shall be filed in the main office of the department and the amended map shall thereupon in all respects and for all purposes supersede the map previously filed.

5. If the commissioner shall determine, prior to the filing of a copy of such acquisition map in the office of the county clerk or register as provided in section four hundred two of the eminent domain procedure law, that such map should be withdrawn, he or she may file a certificate of withdrawal in the offices of the department and of the department of law. Upon the filing of such certificate of withdrawal, the map to which it refers shall be cancelled and all rights thereunder shall cease and determine.

6. The commissioner shall deliver to the attorney general a copy of such acquisition map, whereupon it shall be the duty of the attorney general to advise and certify to the commissioner the names of the owners of the property, easements, interests or rights described in the said acquisition map, including the owners of any right, title or interest therein, pursuant to the requirements of section four hundred three of the eminent domain procedure law.

7. If, at or after the vesting of title to such property in the people of the state of New York as provided for in the eminent domain procedure law, the commissioner shall deem it necessary to cause the removal of an owner or occupant from any real property so acquired, he may cause such owner or occupant to be removed therefrom by proceeding in accordance with section four hundred five of the eminent domain procedure law. The proceeding shall be brought in the name of the commissioner as agent of the state and the attorney general shall represent the petitioner in the proceedings. No execution shall issue for costs, if any, awarded against the state or the commissioner, but they shall be part of the costs of the acquisition of the real property and be paid in like manner. Proceedings may be brought separately against one or more of the owners or occupants of any such property, or one proceeding may be brought against all or several of the owners or occupants of any or all such property within the territorial jurisdiction of the same court, justice or judge; judgment shall be made for immediate removal of persons defaulting in appearance or in answering, or withdrawing their answers, if any, without awaiting the trial or decision of issues raised by contestants, if any.

8. Claims for the value of any property acquired and for legal damages caused by any such acquisition may be adjusted by the commissioner, even though a claim has been filed with the court of claims, if the amount thereof can be agreed upon with the owner or owners thereof. If the amount of a claim cannot be agreed upon, the commissioner shall offer to the owner or owners the amount determined by the commissioner to be the value of such claim. Upon the acceptance of such offer the commissioner shall enter into an agreement with such owner or owners providing for

such payment with interest thereon, if any, as allowed by law and reserving to such owner or owners the right to file such claim with the court of claims or if a claim has been filed reserving the right to prosecute said claim. The reservation of the right to file said claim in the court of claims shall not extend or affect in any way the time limited for the filing of such claim as provided for in the court of claims act. The failure of the owner or owners to file said claim within the time of filing claims specified by the court of claims act shall be deemed an acceptance of the amount paid as full settlement of such claim. If such offer is refused by the owner or owners, or is not accepted within ninety days after notification by the commissioner of such offer by registered mail, interest on the amount of the claim so offered shall be suspended from the date of such refusal or the expiration of such ninety days, whichever is earlier, to the date of the entry of judgment in the court of claims. If such offer is refused or is not accepted within said ninety days the offer shall be deemed withdrawn and may be revived only at the discretion of the commissioner. Upon making any agreement provided for in section three hundred four of the eminent domain procedure law, the commissioner shall deliver to the comptroller such agreement and a certificate stating the amount due such owner or owners thereunder on account of such acquisition of his or their property and the amounts so fixed shall be paid out of the state treasury after audit by the comptroller from moneys appropriated for the acquisition of such real property, but not until there shall have been filed with the comptroller a certificate of the attorney general showing the person or persons claiming the amounts so agreed upon to be legally entitled thereto.

9. Application for reimbursement of incidental expenses as provided in section seven hundred two of the eminent domain procedure law shall be made to the commissioner upon forms prescribed by him and shall be accompanied by such information and evidence as the commissioner may require. Upon approval of such application, the commissioner shall deliver a copy thereof to the comptroller together with a certificate stating the amount due thereof, and the amount so fixed shall be paid out of the state treasury after audit by the comptroller from monies appropriated for the acquisition of property under this section.

10. The commissioner, with the approval of the director of the budget, shall establish and may from time to time amend rules and regulations authorizing the payment of actual reasonable and necessary moving expenses of occupants of property acquired pursuant to this section; of actual direct losses of tangible personal property as a result of moving or discontinuing a business or farm operation, but not exceeding an amount equal to the reasonable expenses that would have been required to relocate such property, as determined by the commissioner; and actual reasonable expenses in searching for a replacement business or farm; or in hardship cases for the advance payment of such expenses and losses. For the purposes of making payment of such expenses and losses only the term "business" means any lawful activity conducted primarily for assisting in the purchase, sale, resale, manufacture, processing or marketing of products, commodities, personal property or services by the erection and maintenance of an outdoor advertising display or displays, whether or not such display or displays are located on the premises on which any of the above activities are conducted. Such rules and regulations may further define the terms used in this subdivision. In lieu of such actual reasonable and necessary moving expenses, any such displaced owner or tenant of residential property may elect to accept a moving expense allowance, plus a dislocation allowance, determined in accordance with a schedule prepared by the commissioner and made a part of such rules and regulations. In lieu of such actual reasonable and necessary moving expenses, any such displaced owner or tenant of commercial property who relocates or discontinues his business or farm operation may elect to accept a fixed relocation payment in an amount equal to the average annual net earnings of the business or farm operation, except that such payment shall be not less than two thousand five hundred dollars nor more than ten thousand dollars. In the case of a business, no such fixed relocation payment shall be made unless the commissioner finds and determines that the business cannot be relocated without a substantial loss of its existing patronage, and that the business is not part of a commercial enterprise having at least one other establishment, which is not being acquired by the state or the United States, which is engaged in the same or similar business. In the case of a business which is to be discontinued but for which the

findings and determinations set forth above cannot be made, the commissioner may prepare an estimate of what the actual reasonable and necessary moving expenses, exclusive of any storage charges, would be if the business were to be relocated and enter into an agreed settlement with the owner of such business for an amount not to exceed such estimate in lieu of such actual reasonable and necessary moving expenses. Application for payment under this subdivision shall be made to the commissioner upon forms prescribed by him and shall be accompanied by such information and evidence as the commissioner may require. Upon approval of such application, the commissioner shall deliver a copy thereof to the comptroller together with a certificate stating the amount due thereunder, and the amount so fixed shall be paid out of the state treasury after audit by the comptroller from moneys appropriated for the acquisition of property under this section. As used in this subdivision the term "commercial property" shall include property owned by an individual, family, partnership, corporation, association or a nonprofit organization and includes a farm operation. As used in this subdivision the term "business" means any lawful activity, except a farm operation, conducted primarily for the purchase, sale, lease and rental of personal and real property, and for the manufacture, processing, or marketing of products, commodities, or any other personal property; for the sale of services to the public; or by a nonprofit organization.

11. Authorization is hereby given to the commissioner to make supplemental relocation payments, separately computed and stated, to displaced owners and tenants of residential property acquired pursuant to this section who are entitled thereto, as determined by him. The commissioner, with the approval of the director of the budget, may establish and from time to time amend rules and regulations providing for such supplemental relocation payments. Such rules and regulations may further define the terms used in this subdivision. In the case of property acquired pursuant to this section which is improved by a dwelling actually owned and occupied by the displaced owner for not less than one hundred eighty days immediately prior to initiation of negotiations for the acquisition of such property, such payment to such owner shall not exceed fifteen thousand dollars. Such payment shall be

the amount, if any, which, when added to the acquisition payment equals the average price, established by the commissioner on a class, group or individual basis, required to obtain a comparable replacement dwelling that is decent, safe and sanitary to accommodate the displaced owner, reasonably accessible to public services and places of employment and available on the private market, but in no event shall such payment exceed the difference between acquisition payment and the actual purchase price of the replacement dwelling. Such payment shall include an amount which will compensate such displaced owner for any increased interest costs which such person is required to pay for financing the acquisition of any such comparable replacement dwelling. Such amount shall be paid only if the dwelling acquired pursuant to this section was encumbered by a bona fide mortgage which was a valid lien on such dwelling for not less than one hundred eighty days prior to the initiation of negotiations for the acquisition of such dwelling. Such amount shall be equal to the excess in the aggregate interest and other debt service costs of that amount of the principal of the mortgage on the replacement dwelling which is equal to the unpaid balance of the mortgage on the acquired dwelling, over the remainder term of the mortgage on the acquired dwelling, reduced to discounted present value. The discount rate shall be the prevailing interest rate paid on savings deposits by commercial banks in the general area in which the replacement dwelling is located. Any such mortgage interest differential payment shall, notwithstanding the provisions of section twenty-six-b of the general construction law, be in lieu of and in full satisfaction of the requirements of such section. Such payment shall include reasonable expenses incurred by such displaced owner for evidence of title, recording fees and other closing costs incident to the purchase of the replacement dwelling, but not including prepaid expenses. Such payment shall be made only to a displaced owner who purchases and occupies a replacement dwelling which is decent, safe and sanitary within one year subsequent to the date on which he is required to move from the dwelling acquired pursuant to this section or the date on which he receives from the state final payment of all costs of the acquired dwelling, whichever occurs later, except advance payment of such amount may be made in hardship cases. In the case of property acquired pursuant to this section from which an individual or family, not otherwise eligible to

receive a payment pursuant to the above provisions of this subdivision, is displaced from any dwelling thereon which has been actually and lawfully occupied by such individual or family for not less than ninety days immediately prior to the initiation of negotiations for the acquisition of such property, such payment to such individual or family shall not exceed four thousand dollars. Such payment shall be the amount which is necessary to enable such individual or family to lease or rent for a period not to exceed four years, a decent, safe, and sanitary dwelling of standards adequate to accommodate such individual or family in areas not generally less desirable in regard to public utilities and public and commercial facilities and reasonably accessible to his place of employment, but shall not exceed four thousand dollars, or to make the down payment, including reasonable expenses incurred by such individual or family for evidence of title, recording fees, and other closing costs incident to the purchase of the replacement dwelling, but not including prepaid expenses, on the purchase of a decent, safe and sanitary dwelling of standards adequate to accommodate such individual or family in areas not generally less desirable in regard to public utilities and public and commercial facilities, but shall not exceed four thousand dollars, except if such amount exceeds two thousand dollars, such person must equally match any such amount in excess of two thousand dollars, in making the down payment. Such payments may be made in installments as determined by the commissioner. Application for payment under this subdivision shall be made to the commissioner upon forms prescribed by him and shall be accompanied by such information and evidence as the commissioner may require. Upon approval of such application, the commissioner shall deliver a copy thereof to the comptroller, together with a certificate stating the amount due thereunder, and the amount so fixed shall be paid out of the state treasury after audit by the comptroller from moneys appropriated for the acquisition of property under this section.

12. The owner of any real property so acquired may present to the court of claims, pursuant to section five hundred three of the eminent domain procedure law, a claim for the value of such property acquired and for legal damages caused by such acquisition, as provided by law for the filing of claims with the court of claims. Awards and judgments of

the court of claims shall be paid in the same manner as awards and judgments of that court for the acquisition of lands generally and shall be paid out of the state treasury after audit by the comptroller from moneys appropriated for the acquisition of such real property.

14. If the commissioner shall determine subsequent to the acquisition of a temporary easement in any real property that the purposes for which such easement right was acquired have been accomplished and that the exercise of such easement is no longer necessary, he shall make his certificate that the exercise of such easement is no longer necessary and that such easement right is therefore terminated, released and extinguished. The commissioner shall cause such certificate to be filed in the office of the department of state and upon such filing all rights acquired by the state in such property shall cease and determine. The commissioner shall cause a certified copy of such certificate as so filed in the office of the department of state to be mailed to the owner of the property affected, as certified by the attorney general, if the place of residence of such owner is known or can be ascertained by a reasonable effort and such commissioner shall cause a further certified copy of such certificate to be filed in the office of the recording officer of each county in which the property affected or any part thereof is situated. On the filing of such certified copy of such certificate with such recording officer, it shall be his duty to record the same in his office in the books used for recording deeds and to index the same against the name of the people of the state of New York as grantor.

15. Notwithstanding any other provision of this section, the commissioner shall have the power to acquire by grant or purchase, in the name of the people of the state of New York, any property which he deems necessary for any of the purposes provided for in this section and may also acquire for such purposes from the Palisades interstate park commission, in the name of the people of the state of New York, such lands and such easements, licenses, permits and other rights over lands as the said commission is authorized to grant, sell, exchange or convey. When the acquisition by appropriation, grant or purchase of property deemed necessary for departmental purposes would result in substantial

consequential damages to the owner's remaining property, due to loss of access, severance or control of access, the commissioner of transportation, for and in behalf of the people of the state of New York, may acquire by purchase or grant all or any portion of such remaining property. Payment therefor, if any, shall be made in the manner prescribed in this section for the payment of adjusted appropriation claims, provided, however, that no real property shall be so acquired unless the title thereto shall be approved by the attorney general.

§ 403. Hospitals; property; authority to acquire and to hold. 1. The following state hospitals are hereby continued in the department for the purposes for which they have been respectively established:

- (a) The Helen Hayes hospital;
- (b) Roswell Park Cancer Institute;
- (c) The New York state home for veterans and their dependents at Oxford;
- (d) The New York state home for veterans in the city of New York;
- (e) The New York state home for veterans in western New York;
- (f) The New York state home for veterans in the lower-Hudson Valley.

2. Notwithstanding any other inconsistent provisions of law, including, but not limited to, article four-C of the economic development law, and subject to the provisions of any lease, loan agreement or other agreement with the dormitory authority of the state of New York or any predecessor or successor agency or corporation, the commissioner, with the approval of the director of the budget, may contract with the Roswell Park Cancer Institute corporation, for the transfer of the operations of the Roswell Park Cancer Institute or any part thereof, practice plan or of any other program operated by such hospital. Such contract shall include terms and conditions under which the Roswell Park Cancer Institute corporation may issue bonds, notes or other evidences of indebtedness. Payments made pursuant to such contract or any other contracts between the department of health and the Roswell Park Cancer Institute corporation shall be limited to amounts made available pursuant to appropriations. Upon the transfer of the

operations of Roswell Park Cancer Institute to the Roswell Park Cancer Institute corporation, the Roswell Park Cancer Institute corporation shall operate the Roswell Park Cancer Institute for the department in accordance with the terms of any lease or other agreement between the department and the dormitory authority pertaining to the use, operation, maintenance and replacement of Roswell Park Cancer Institute.

§ 403-a. The New York state home for veterans and their dependents at Oxford. The New York state home for veterans and their dependents at Oxford shall be subject to the provisions of this article except when such provisions are inconsistent with the provisions of article twenty-six-A of this chapter.

§ 403-b. The New York state home for veterans in the city of New York. There is hereby established in the city of New York a New York state home for veterans. Such home for veterans shall be subject to the provisions of this article except when such provisions are inconsistent with the provisions of article twenty-six-A of this chapter.

§ 403-c. The New York state home for veterans in western New York. There is hereby established a state home for veterans in western New York. Such home for veterans shall be subject to the provisions of this article except when such provisions are inconsistent with the provisions of article twenty-six-A of this chapter.

§ 403-d. The New York state home for veterans in the lower-Hudson Valley. There is hereby established a state home for veterans in the lower-Hudson Valley. Such home for veterans shall be subject to the provisions of this article except when such provisions are inconsistent with the provisions of article twenty-six-A of this chapter.

§ 404. Hospitals; property; authority to acquire and to hold. 1. The

board of visitors of each state hospital in the department, as the agent of the department, is hereby authorized to take and hold, in the name of and for the people of the state, by grant, gift, devise or bequest, property to be applied, principal or income, or both, for the benefit of the hospital, institution or of any patient or patients therein or to the maintenance and the general uses of the hospital or institution.

2. No property shall be taken or held as provided by this section, except with the approval of the commissioner unless the rules of the commissioner otherwise provide. Utilization and administration of property so taken and held shall be subject to the rules of the commissioner.

3. Property taken and held as provided by this section shall be applied or expended for the purpose specified by the donor, subject to the rules of the commissioner.

4. The expenditure of moneys derived from any source pursuant to the provisions of this section, including income, shall be under the immediate direction of the hospital, or treasurer of the institution, except as the rules of the commissioner may otherwise provide.

§ 405. Hospitals; visitors and officers; oaths and bonds. 1. Each director, member of the board of visitors, and treasurer of the several state hospitals in the department shall take the constitutional oath of office.

§ 406. Hospitals; refunds, waivers and compromises of bills. 1. Moneys heretofore or hereafter received by the department for the accounts of any of the hospitals or institutions of the department may be refunded to the person or party for whose account same were received, and within six years thereafter upon satisfactory proof being submitted to the commissioner that:

a. such moneys were in excess of the charges imposed upon or incurred

by the party, pursuant to law; or,

b. such moneys were received as reimbursement for care, maintenance and treatment of patients, and such care, maintenance and treatment has not been rendered or furnished; or,

c. such moneys were received from the funds of patients not available for payment for the care, maintenance and treatment of patients.

2. Notwithstanding the provisions of section one hundred twenty-one of the state finance law, such refunds shall, upon approval by the commissioner and after audit by the comptroller, be paid from any moneys in the custody of the department received as reimbursement for the care, maintenance and treatment of patients in the several hospitals in the department.

3. The commissioner may in his discretion, in proper cases, where substantial justice will best be served thereby, waive bills for the maintenance, care and treatment received or furnished to patients in any of the hospitals or institutions of the department or compromise any portion of such bills. Such waiver or compromise shall be made only upon prior approval of the comptroller and the attorney general when they deem it to be for the best interest of the state.

§ 407. Hospitals; privileges to students. 1. Whenever the person or persons having lawful control and management over any public hospital in any city or county in this state, shall grant to matriculated students of any legally incorporated medical college in said city or county, privileges of admission to such hospital for hearing clinics or lectures, or receiving medical or surgical instruction therein, the like privileges and advantages shall be granted to the matriculated students in each and all legally incorporated medical colleges in said city and county who may desire the same, without distinction or preference, and upon equal terms and conditions as to all.

2. Nothing in this section shall prevent the directors of such

hospitals from limiting the attendance of students in such hospitals to a number compatible with the welfare of patients. But in such limitation they shall receive students from such legally incorporated medical colleges applying for such admission in proportion to the number of students in attendance upon such college.

§ 408. Hospitals; admission of patients; in general. 1. If in the judgment of the director of a hospital in the department the number of patients of the hospital at any time so far exceeds its proper capacity that suitable care, training or discipline cannot be given to additional patients, or for other reasons the admission of such additional patients is impracticable, the commissioner in his discretion, may suspend the admission of patients to such hospital until such time as they may properly be admitted.

2. The commissioner shall promptly notify courts and other public officers empowered to commit persons to such hospital of any such suspension of admission and of its termination. A person committed to such hospital before the court receives notice of such a suspension may be recommitted to another hospital to which he might have been lawfully committed in the first instance.

3. In the admission of patients to such hospital the several counties and the city of New York shall, so far as practicable, be entitled to have in such hospital, patients in the ratio which their respective populations bear to the population of the state as ascertained by the latest federal census or state enumeration.

§ 409. Department of health income fund. 1. There is established in the custody of the comptroller a special account, to be known as the department of health income fund.

2. (a) The commissioner shall, after the first day of July, nineteen hundred seventy-one, pay over moneys received by the department including, subject to subdivision six of this section, moneys received

from the Roswell Park Cancer Institute corporation for the care, maintenance and treatment of patients at state hospitals in the department as enumerated in section four hundred three of this chapter, together with money received from fees, including parking fees, refunds, reimbursements, payments received pursuant to leases, sales of property and miscellaneous receipts of such hospitals other than gifts, grants, bequests and moneys received under research contracts, and clinical practice income received pursuant to a clinical practice plan established pursuant to subdivision fourteen of section two hundred six of this chapter except for the amount of money required by the comptroller to be maintained on deposit in the department of health income fund pursuant to paragraph (c) of this subdivision less payments required to be made into pools created by this chapter and for assessments established pursuant to this chapter and less refunds made pursuant to law, to the comptroller to be deposited by the comptroller in the department of health income fund. Such moneys shall be kept separate and shall not be commingled with any other moneys in the hands of the comptroller. All deposits of such money shall, if required by the comptroller, be secured by obligations of the United States or of the state of market value equal at all times to the amount of the deposit and all banks and trust companies are authorized to give such securities for such deposits. The commissioner shall identify to the comptroller moneys received from Roswell Park Cancer Institute corporation or its subsidiaries.

(b) Subject to the terms of any agreement between the department and the dormitory authority, any such moneys in the department of health income fund not required for immediate use, may, in the discretion of the comptroller, be invested by the comptroller in obligations of the United States or the state or obligations the principal and interest of which are guaranteed by the United States or the state.

(c) The comptroller shall at all times maintain on deposit in the department of health income fund the aggregate amount of money needed by the department during the next succeeding six calendar months to comply in full with all obligations of the department under the terms of every lease, sublease or agreement of the department with the dormitory authority which is then in effect, including without limitation by the specification thereof, (i) the amount needed to make rental payments

thereunder during such semiannual period, and (ii) the amount needed to establish and maintain reserves thereunder during such period.

(d) The comptroller shall from time to time but in no event later than the last day of March, June, September and December of each year pay over and deposit in the special revenue funds - other, miscellaneous special revenue fund - 339, Roswell Park cancer institute account, Helen Hayes hospital account, New York state home for veterans and their dependents at Oxford account, western New York veterans' home account and New York state home for veterans in the lower-Hudson Valley account, in accordance with directions from the commissioner of health concerning the distribution of revenues among the various accounts, all moneys in the department of health income fund in excess of the aggregate amount of money required to be maintained in the department of health income fund pursuant to paragraph (c) of this subdivision. Prior to making any such transfer, the comptroller shall make and deliver to the director of the budget and to the dormitory authority his certificate stating the aggregate amount to be maintained on deposit in the department of health income fund to comply in full with the provision of paragraph (c) of this subdivision. When further directed by the commissioner, the comptroller shall transfer revenues and/or appropriations between and among these accounts and the special revenue funds - other, miscellaneous special revenue fund - 339, New York city veteran's home account. For purposes of transferring appropriations it is intended that the following accounts be understood to be part of the same program and same fund for purposes of section fifty-one of the state finance law, thereby authorizing unlimited interchangeability of appropriated amounts between the following accounts in the special revenue funds - other, miscellaneous special revenue fund - 339: Roswell Park Cancer Institute Account, Helen Hayes Hospital Account, New York State Home for Veterans and Their Dependents at Oxford Account, Western New York Veterans' Home Account, New York State Home for Veterans in the lower-Hudson Valley Account, and New York City Veterans' Home Account. The comptroller shall, as determined by the commissioner and consistent with any repayment agreement entered into between the director of the budget and the commissioner, transfer funds from the Roswell Park cancer institute account, Helen Hayes hospital account, New York state home for veterans and their dependents at Oxford account, western New York

veterans' home account or New York state home for veterans in the lower-Hudson Valley account to the department of health services account to repay all or part of any outstanding liabilities in the health services account attributed to the respective hospitals for which such accounts were established.

3. To secure the payment of any money due or to become due in any year under any lease, sublease or agreement entered into between the department and the dormitory authority, the commissioner may pledge or assign to the dormitory authority all or any moneys in the department of health income fund established pursuant to this section, and any and all moneys which may be receivable by the department and credited to such department of health income fund in the future, and any right, title and interest of the department in and to the money in or to be deposited in such department of health income fund.

4. The moneys in the department of health income fund shall be paid out of such fund on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner, or by an officer or employee of the department designated by the commissioner, notwithstanding the provisions of any general or special law to the contrary.

5. Notwithstanding any inconsistent provision of this section or any other law to the contrary, including, but not limited to, section four of the state finance law, the comptroller shall no less than biweekly pay any moneys which the commissioner identifies as being attributed to the operation of the Roswell Park Cancer Institute corporation or the properties leased to it by the state or subsidiaries of such corporation, which are in excess of the amounts required to comply with the provisions of paragraph (c) of subdivision two of this section, into a depository account owned and controlled by the Roswell Park Cancer Institute corporation.

6. Notwithstanding the foregoing provisions of this section, upon the payment or provision for payment of all outstanding bonds issued on or before March thirty-first, two thousand twenty-five by the dormitory authority to make loans to the department to finance or refinance state

hospital facilities in accordance with the terms of the bond resolution under which such bonds were issued, the provisions of subdivisions two and five of this section requiring (i) the payment and identification by the department to the comptroller of moneys received from the Roswell Park Cancer Institute corporation, (ii) the deposit and maintenance of such moneys from the Roswell Park Cancer Institute corporation by the comptroller in the department of health income fund, and (iii) the release of excess moneys in the department of health income fund attributed to the operation of the Roswell Park Cancer Institute corporation or its subsidiaries, shall no longer be applicable and, thereafter, all such moneys from the operation of the Roswell Park Cancer Institute corporation shall remain in the custody and/or control of the corporation and/or its subsidiaries.

§ 409-a. Department of health New York city veterans home income fund.

1. There is established in the custody of the comptroller a special account, to be known as the "department of health New York city veterans home income fund", which shall be referred to in this section as "the fund".

2. (a) The commissioner shall, after the first day of July, nineteen hundred ninety-one, pay over moneys received by the department for the care, maintenance and treatment of patients at the New York state home for veterans in the city of New York, together with moneys received from fees, including parking fees, refunds, reimbursements, sales of property and miscellaneous receipts of such home other than gifts, grants, bequests and moneys received under research contracts to the comptroller to be deposited by the comptroller in the fund. Such moneys shall be kept separate and shall not be commingled with any other moneys in the hands of the comptroller. All deposits of such money shall, if required by the comptroller, be secured by obligations of the United States or of the state of market value equal at all times to the amount of the deposit and all banks and trust companies are authorized to give such securities for such deposits.

(b) Subject to the terms of any agreement between the department and the dormitory authority, any such moneys in the fund not required for

immediate use, may, in the discretion of the comptroller, be invested by the comptroller in obligations of the United States or the state or obligations the principal and interest of which are guaranteed by the United States or the state.

(c) The comptroller shall at all times maintain on deposit in the fund the aggregate amount of money needed by the department during the next succeeding six calendar months to comply in full with all obligations of the department under the terms of any lease, sublease or agreement of the department with the dormitory authority relating to the New York state home for veterans in the city of New York which is then in effect, including without limitation by the specification thereof, (i) the amount needed to make rental or other payments thereunder during such semiannual period and (ii) the amount needed to establish and maintain reserves thereunder during such period.

(d) The comptroller shall from time to time but in no event later than the last day of March, June, September and December of each year pay over and deposit in the special revenue funds - other, miscellaneous special revenue fund - 339, New York city veterans' home account, all moneys in the fund in excess of the aggregate amount of money required to be maintained in the department of health New York City veterans home income fund pursuant to paragraph (c) of this subdivision. Prior to making any such transfer, the comptroller shall make and deliver to the director of the budget and to the dormitory authority a certificate stating the aggregate amount to be maintained on deposit in the fund to comply in full with the provision of paragraph (c) of this subdivision. When further directed by the commissioner, the comptroller shall transfer revenues and/or appropriations between and among this account and the special revenue funds - other, miscellaneous special revenue fund - 339, Roswell Park cancer institute account, Helen Hayes hospital account, New York state home for veterans and their dependents at Oxford account, western New York veteran's home account and New York state home for veterans in the lower-Hudson Valley account. For purposes of transferring appropriations it is intended that the following accounts be understood to be part of the same program and same fund for purposes of section fifty-one of the state finance law, thereby authorizing unlimited interchangeability of appropriated amounts between the following accounts in the special revenue funds - other, miscellaneous

special revenue fund - 339: Roswell Park Cancer Institute Account, Helen Hayes Hospital Account, New York State Home for Veterans and Their Dependents at Oxford Account, Western New York Veterans' Home Account, New York State Home for Veterans in the lower-Hudson Valley Account, and New York City Veterans' Home Account. The comptroller shall, as determined by the commissioner and consistent with any repayment agreement entered into between the director of the budget and the commissioner, transfer funds from the New York city veteran's home account to the department of health services account to repay all or part of any outstanding liabilities in the health services account attributed to the New York city veterans' home.

3. To secure the payment of any money due or to become due in any year under any lease, sublease or agreement entered into between the department and the dormitory authority relating to the New York state home for veterans in the city of New York, the commissioner may pledge or assign to the dormitory authority all or any moneys in the fund established pursuant to this section, and any and all moneys which may be receivable by the department and credited to such fund in the future, and any right, title and interest of the department in and to the money in or to be deposited in such fund.

4. The moneys in the fund shall be paid out of such fund on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner, or by an officer or employee of the department designated by the commissioner, notwithstanding the provision of any general or special law to the contrary.

§ 409-b. Distribution of surplus revenue. 1. Notwithstanding any inconsistent provisions of section four hundred nine of this article, the commissioner shall establish a plan for distribution of surplus revenue to the institutional program in accordance with the provisions of this section.

2. The commissioner shall annually certify to the director of the budget when there are sufficient receipts deposited to the department of

health income fund to meet the department's revenue target for debt service and institutional operations established in the budget for the fiscal year.

3. The commissioner shall allocate the full amount of the receipts received from state hospitals within the department which exceed the amount certified to the director of the division of the budget pursuant to subdivision two of this section to be paid over and deposited in the surplus revenue account established pursuant to subdivision four of this section to be allocated to such facilities in accordance with subdivision five of this section.

4. There shall be established within the special revenue funds - other a department of health facility surplus revenue account. All surplus revenues allocated pursuant to subdivision three of this section shall be paid over and deposited to the department of health facility surplus revenue account.

5. The commissioner shall segregate any funds available in the department of health facility surplus revenue account pursuant to subdivision four of this section to the state hospitals within the department based on consideration of the following factors: (i) the proportion of funds that each facility contributes to such surplus revenue; and (ii) the amounts each facility contributed to the department of health income fund under section four hundred nine of this article. The amounts shall be allocated to each facility in accordance with a plan, subject to the approval of the commissioner, submitted by each facility to ensure that such funds are used for non-recurring expenses including personal services contracts and equipment leases and rentals that are for no more than one year, but are potentially renewable and meet all applicable state purchasing requirements.

§ 409-c. Powers and duties of the commissioner; administrative and fiscal functions. 1. Notwithstanding the provisions of sections forty-four, forty-nine, fifty, fifty-one and ninety-three of the state finance law, section nine of the public buildings law or any other

provision of law to the contrary, the commissioner is authorized and empowered:

(a) to expend all lump sum or consolidated appropriations and other appropriations made for the institutional program. Within aggregate funds available for expenditures, the state comptroller shall draw warrants for the payment of all vouchers approved by the commissioner, or by such person as shall be designated by the commissioner by a rule or written direction filed with the state comptroller. Such lump sum or consolidated appropriations made for personal service, or for maintenance and operation or for non-personal service, or maintenance undistributed including personal service, other than appropriations from proprietary or fiduciary funds, shall be available for payments for personal service, or maintenance and operation or for non-personal service, or for maintenance undistributed including personal service upon the filing of a schedule of positions and salaries and the amounts to be available for other personal service classes of expenditure, and for the expenses of maintenance and operation, or for non-personal service with the director of the budget, chairman of the senate finance committee, chairman of the assembly ways and means committee, and the state comptroller. Any such schedule may be amended and such amendment shall be filed with the officers named above. The state comptroller is authorized to pay any amounts required for the salaries and related employment benefits of employees of the institutional program from any appropriations available therefor.

(b) To increase or decrease capital projects fund appropriations by transfer or interchange as follows:

(i) Amounts appropriated for the programs or purposes or for any item or items within such programs or purposes of the institutional program in the department from a particular fund or funds, excluding appropriations for major new facility construction or comprehensive facility renovation or modernization projects, in a fiscal year may be interchanged between items within the same program or purposes of an institution, or with other items appropriated from such fund not in the same program or purpose within an institution, but which are contained in the state comptroller's classification of items as last promulgated pursuant to a certificate of allocation. Such certificate shall be submitted by the commissioner to the state comptroller with copies to be

sent to the chairs of the senate finance committee and the assembly ways and means committee and the director of the budget for informational purposes only.

2. (a) Notwithstanding any inconsistent provision of section ninety-three of the state finance law or any other law to the contrary, any capital projects fund appropriation for state hospitals in the department shall be available to the department upon issuance of a certificate of approval of availability by the director of the budget. The certificate shall be for so much as shall be necessary to accomplish the purposes described in the report from the department specifying the scope of the project and the project budget within the limits of the appropriation and a copy of such certificate of approval shall be filed with the state comptroller, the chair of the senate finance committee and the chair of the assembly ways and means committee. Moneys so approved shall be paid on the audit and warrant of the state comptroller pursuant to vouchers approved by the commissioner.

(b) Notwithstanding any inconsistent provision of section nine of the public buildings law or any other law to the contrary, when the commissioner shall determine that there is a construction emergency, as defined in section nine of the public buildings law, the commissioner is empowered and authorized to exceed the limit of forty thousand dollars but not to exceed the limit of two hundred thousand dollars for such project and may utilize any capital projects fund appropriation for state hospitals within the department for the purposes of addressing such construction emergency.

3. The commissioner shall provide the chairs of the senate finance committee and the assembly ways and means committee and the director of the budget with: (i) quarterly reports of all expenditures within the institutional program pursuant to this section on the fifteenth day of July, October, January and April of each year; and (ii) a report on the health care activities of the facilities within the institutional program pursuant to this section and their participation in health care delivery networks, either directly or under contract on or around submission of the annual budget request, but in no event later than October fifteenth of each year. This report shall provide information

regarding: the impact of existing managed care contracts on services, census levels, operational costs and revenue; and the impact of planned expansion of existing managed care networks, including anticipated changes in service areas, census, operating costs and revenue projected as a result of such expansion.

4. Notwithstanding any provision of section one hundred sixty-three of the state finance law or any other law, rule or regulation to the contrary, the commissioner may:

(a) authorize contracts with public, non-profit or business entities for the provision of general comprehensive and specialty health care services in department inpatient or outpatient hospitals, clinics or other ancillary facilities, as defined in section four hundred three of this title, through managed care networks or other health care contractual arrangements for the provision of health care services. Consistent with applicable laws and regulations, the commissioner shall develop policies concerning the terms and conditions for such contracts including length of term, contributions, evidence of insurance, risk assumption and indemnification. Health care services to be provided under such contracts may be delivered directly by state hospitals in the department, as defined in section four hundred three of this title, or, with respect to health care services not provided by such hospitals, through contract, agreement or other arrangement with physicians and other health practitioners and providers or professional corporations, not-for-profit or business entities comprised thereof. Contracts for the provision of health care services hereunder: (i) shall be consistent with applicable provisions of agreements between the state and employee organizations pursuant to article fourteen of the civil service law; (ii) may be entered into without formal competitive bidding subject to the policies of the commissioner which shall include requirements for comparative review or other competitive processes where appropriate; and (iii) shall not increase operating costs above resulting increases in revenue such that expenditures related to services provided pursuant to such contracts will be limited to revenues projected to be received over the life of the contract. Before entering into any contract pursuant to this paragraph, the commissioner shall provide a written assurance to the director of the budget that such contract will not require any

additional resources from the state of New York not supported by contract revenues, based on the projected financial and economic analyses of the proposed contract submitted by the facility, including relevant assumptions regarding the projection.

* (b) notwithstanding section one hundred twelve of the state finance law to the contrary, authorize contracts for the purchase of goods and services for state hospitals in the department, as defined in section four hundred three of this title, without prior review and approval of any other state office or agency and subject to the commissioner's rules and regulations: (i) for any contract which does not exceed one hundred thousand dollars; or (ii) for joint or group purchasing arrangements which do not exceed three hundred thousand dollars. The state comptroller shall have ninety days to review arrangements over the limitations prescribed pursuant to this subparagraph. Purchases made pursuant to such joint or group purchasing arrangements shall not include services and be made from contracts awarded by a regionally or nationally recognized purchasing organization, and contracts with a regionally or nationally recognized purchasing organization shall be made on a competitive basis.

* NB Repealed March 31, 2027

(c) authorize contracts for the participation by state hospitals in the department, as defined in section four hundred three of this title, in joint and cooperative programs and arrangements for the delivery of health care services, or for the planning and administration thereof, with public, non-profit or business entities, including programs and arrangements on a regional or national basis.

(d) authorize the department to: (i) lease, sublease or otherwise make available in accordance with the commissioner's policies, space or facilities within its hospitals, as defined in section four hundred three of this title, to one or more practitioners or public, non-profit or business entities for the purposes specified in paragraphs (a) and (c) of this subdivision; or (ii) to lease or sublease any facilities or other property necessary for the delivery of health care services in accordance with the provisions of paragraphs (a) and (b) of this subdivision.

(e) nothing contained in this subdivision shall in any way alter or impair the rights provided pursuant to a collective bargaining

agreement, state law implementing such agreement or under article fourteen of the civil service law of all members of certified bargaining units currently or hereafter employed by the department in hospitals, as defined in section four hundred three of this title, and all certified employee organizations and negotiating units of such employees shall continue in accordance with the provisions of article fourteen of the civil service law. The commissioner shall assure that any contract or agreement entered into for the provision of general comprehensive and specialty health care services in department hospitals, as defined in section four hundred three of this title, through participation in managed care networks or other joint and cooperative programs and arrangements including those on a regional basis in fulfillment of any provision of this subdivision, the service of which is being provided by department employees at hospitals defined in section four hundred three of this title who are members of certified bargaining units at such hospital will be subject to the terms and conditions of any current or future collectively negotiated agreement between the state and certified employee organizations pursuant to article fourteen of the civil service law.

5. The commissioner shall submit a report to the governor, the temporary president of the senate, the speaker of the assembly and the office of the state comptroller on or before May first, two thousand two, which shall include a record of all group purchasing arrangements, including for each group purchasing arrangement: the name of the purchasing organization, overall contract amount, dollar value of purchases made by fiscal year, description of the commodities purchased, and methodology used to determine the cost effectiveness of such purchase.

§ 410. Hospitals; reimbursement. No corporation organized and operating in accordance with article forty-three of the insurance law, organization operating in accordance with the provisions of article forty-four of this chapter, commercial insurer licensed to do business in this state and authorized to write accident and health insurance or payor responsible for payments pursuant to the workers' compensation

law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law or the comprehensive motor vehicle insurance reparations act shall decline or refuse to make payments to a state hospital in the department as enumerated in section four hundred three of this chapter, in accordance with rates of payment established for such payor pursuant to article twenty-eight of this chapter for such hospital or hospital charges for services not covered by rates of payment, for hospital or health-related services provided to subscribers, beneficiaries, or enrolled members that would be a covered service for which such payor would make payment if provided at a voluntary non-profit hospital issued an operating certificate pursuant to section twenty-eight hundred five of this chapter, or, for a payor that provides for participating provider agreements, to enter into a participating provider agreement with such state hospital.

TITLE II

HOSPITALS: BOARDS OF VISITORS

Section 420. Boards of visitors; appointment.

421. Boards of visitors; officers; meetings.

422. Boards of visitors; compensation and expenses of members.

423. Boards of visitors; general powers and duties.

424. Boards of visitors; access to hospital; books, records and accounts.

425. Boards of visitors; reports to commissioner and governor.

§ 420. Boards of visitors; appointment. 1. (a) Subject to the provisions of this chapter, each hospital in the department shall continue to have a board of seven visitors, to be appointed by the governor by and with the advice and consent of the senate; provided however that in the case of the state institute for the study of malignant diseases one of the seven members of the board of visitors shall be the commissioner, ex-officio.

(b) At least two members of the board of visitors of the Helen Hayes hospital shall be duly licensed physicians and at least two members shall be women. This provision shall not affect the offices of the

present members; but appointments hereafter shall be so made as to comply herewith as soon as practicable.

(c) At least two of the members of the board of visitors of the state institute for the study of malignant diseases shall be residents of the city of Buffalo or vicinity and one member of the board of visitors shall be a member of the medical faculty or of the council of the University of Buffalo.

2. (a) The terms of office of the members of the boards of visitors, other than the members of the board of visitors of the state institute for the study of malignant diseases, shall be seven years, and they shall be so appointed that the term of at least one of the members of the board of visitors shall expire on the thirty-first day of December of each year.

(b) The terms of office of the members of the board of visitors of the state institute for the study of malignant diseases shall be five years and they shall be so appointed that the term of at least one of the members shall expire on the thirty-first of December of each year.

3. All vacancies on the several boards of visitors of hospitals in the department shall be filled by the governor in the same manner as original appointments, and the person appointed to fill a vacancy in the board of visitors of a hospital in the department shall hold office for the remainder of the term of the person whom he succeeds.

4. The governor may remove any member or members of a board of visitors for cause after an opportunity to be heard.

5. This section shall not affect the terms of the present members of such board.

6. Notwithstanding any inconsistent provision of this section or any other provision of law to the contrary, upon the transfer to the Roswell Park Cancer Institute corporation of the operations of the Roswell Park Cancer Institute, the board of visitors of Roswell Park Cancer Institute shall cease to operate and the terms of the current members of the board of visitors shall terminate. In the event that the operations of the

Roswell Park Cancer Institute revert to the department of health, the board of visitors shall be reconstituted and the governor shall make new appointments pursuant to this section.

§ 421. Boards of visitors; officers; meetings. 1. The board of visitors of a hospital in the department shall elect a chairman from among its members.

2. (a) The board of visitors of each hospital in the department, other than the institute for the study of malignant diseases, shall hold regular meetings at least once every three months throughout the year, and cause to be typewritten within ten days after each such meeting, the minutes and proceedings of such meeting, and cause a copy thereof, to be sent forthwith to each member of the board of visitors, to the commissioner and to the governor.

(b) The board of visitors of the state institute for the study of malignant diseases shall meet quarterly to consider the affairs of the institute and at the last quarterly meeting in a calendar year shall prepare and transmit to the commissioner, a report of the work of the institute for the twelve months preceding such meeting.

(c) The board of visitors of each hospital in the department may meet at any time on call of the chairman.

3. Members of a board of visitors who fail to attend meetings of the board at least twice in each calendar year shall be deemed to have vacated their membership in such board of visitors, whereupon the governor shall fill the vacancies so created as provided by this chapter, unless the absence of such visitors shall be excused by the governor.

§ 422. Boards of visitors; compensation and expenses of members. Members of the board of visitors of each hospital in the department shall receive no compensation, but each shall be entitled to receive his expenses actually and necessarily incurred in the performance of his duties.

§ 423. Boards of visitors; general powers and duties. 1. The board of visitors of each hospital in the department shall have the powers and duties expressly conferred or imposed on it by this chapter and such other powers and duties, not inconsistent with law as may be prescribed by rules of the commissioner.

2. Each board of visitors shall:

(a) subject to such rules and the statutory powers of the commissioner, take care of the general interest of the institution and see that its objective is carried into effect;

(b) maintain an effective inspection of the institution, for which purpose the board, or a majority of its members, shall visit and inspect the institution at least once every three months;

(c) keep in a book provided for that purpose, a fair and full record of its activities, which shall be open at all times to the inspection and examination of the governor or of any person appointed by the governor or by either house of the legislature, or to the commissioner or his authorized representatives;

(d) enter in a book, kept at the institution for that purpose, the date of each visit of each visitor;

(e) investigate, hear and ascertain the truth of all charges made against the director or other officer or employee of the institution, issue subpoenas, take and hear testimony in respect to such charges and make its recommendations thereon to the authority having the power to discharge or remove. A witness attending before such board shall be entitled to the same fees as a witness attending before a court of record or a judge thereof, which shall be paid as other institutional charges.

§ 424. Boards of visitors; access to hospital; books, records and accounts. The resident officers of each hospital in the department shall admit the members of the board of visitors of the respective hospital into every part of the hospital and its buildings, and exhibit to them on demand all the books, papers, accounts and writings belonging to the

hospital, or pertaining to its business, management, discipline or government, and furnish copies, abstracts and reports whenever required by them.

§ 425. Boards of visitors; reports to commissioner and governor. 1.

The board of visitors of each hospital in the department shall make a written report to the commissioner and to the governor within ten days after each inspection, such report to be signed by each member making the inspection. Such report shall state in detail the condition of the hospital and of its patients, and such other matters pertaining to the management and affairs thereof as in the opinion of the board of visitors should be brought to the attention of the commissioner or the governor, and may contain recommendations as to needed improvement in the hospital or in its management.

2. Each board of visitors shall make to the commissioner in January of each year a detailed report of the results of its visits and inspections, with suitable suggestions and such other matters as may be required of it by the commissioner for the year ending on the thirty-first day of December preceding the day of such report. Such report shall be prepared by a committee of the board of visitors, subject to the approval of the board.

TITLE IV

HOSPITALS: OFFICERS AND EMPLOYEES

Section 450. Directors of hospitals; qualifications and appointment.

451. Directors of hospitals; removal and suspension.

452. Directors of hospitals; general powers and duties.

453. Treasurers of hospitals; appointment.

454. Treasurers of hospitals; powers and duties.

455. Hospitals; special police officers; powers and duties.

§ 450. Directors of hospitals; qualifications and appointment. 1.

There shall be a director of each state hospital in the department, who

shall be in the competitive class of civil service, and who shall be appointed by the commissioner.

2. The director shall possess the qualifications prescribed by law, or, if no such qualifications be prescribed, such qualifications as may be prescribed in the sanitary code.

3. Before making the appointment of a director of a hospital, the commissioner shall give notice of his intended action to the members of the board of visitors, by registered mail, naming the person whom he proposes to appoint and his place of residence, and shall specify a day, not less than ten days from the mailing of the notice, before which the board of visitors may submit to the commissioner the objections of the board of visitors, if any, to such appointment; and the person named shall not be appointed before such day, except in the case of an express approval by the board of visitors.

4. Subject to removal in the manner provided by law, the director of each hospital in the department now in office is hereby continued in office.

§ 451. Directors of hospitals; removal and suspension. 1. The director of a hospital in the department may be removed by the commissioner for cause stated in writing, after an opportunity has been given the director to be heard thereon. Such action by the commissioner shall be final. The board of visitors of the hospital, however, shall be notified of any such hearing and its members be given an opportunity to be heard thereat. Pending the investigation by the commissioner or board of visitors of any charges against a director, the commissioner may suspend such director.

2. The commissioner may prefer charges of misconduct or incompetency against the director of a hospital in the department, to the board of visitors, and the board of visitors shall thereupon investigate the truth of such charges and make its recommendations thereon to the commissioner, or the commissioner or his duly authorized representative

may investigate any charges of like nature made to the commissioner. The investigating authority may subpoena witnesses, and take and hear testimony.

§ 452. Directors of hospitals; general powers and duties. 1. The director of each hospital in the department shall be the executive officer of the hospital and shall:

(a) be in immediate charge of the activities and management of the hospital, subject to the supervision and control of the commissioner;

(b) except as otherwise provided with respect to the treasurer, and subject to the approval of the commissioner, appoint and remove all members of the staff and all other employees of the hospital;

(c) annually, in the month of January, report to the commissioner of the activities of the hospital for the calendar year ending with the preceding thirty-first day of December;

(d) submit at each meeting of the board of visitors, a report showing changes in population, health of patients, officers and employees; accidents, suicides, unusual sickness, communicable diseases; important occurrences relating to the welfare of the patients and to the management and discipline of the employees, and such other matters as the board of visitors may specify; and,

(e) perform such other duties as the commissioner may require.

2. Nothing in this chapter shall prevent the adoption, by any director of a hospital in the department, of rules pertaining to duties of officers and employees of the hospital under his charge or for internal government, discipline and management of the hospital, consistent with the provisions of the civil service law, the rules promulgated pursuant thereto and the rules of the commissioner, but any rule of the director shall be subject to revocation or suspension by the commissioner.

§ 453. Treasurers of hospitals; appointment. 1. Each hospital in the department shall have a treasurer.

2. (a) The commissioner may appoint such an officer for each hospital.

(b) In the event that the commissioner fails to appoint a treasurer as provided by this section, or in the event of a vacancy occurring in the office of treasurer or pending the appointment of a treasurer, the director of the hospital shall be the treasurer.

(c) During the absence or disability of the treasurer of a hospital, the director thereof shall perform the duties of a treasurer.

§ 454. Treasurers of hospitals; powers and duties. Subject to rules and regulations of the commissioner, the treasurer of each hospital in the department shall:

(a) receive and have the custody of all moneys and securities of the hospital from whatever sources derived, except as otherwise provided by law and keep an accurate record thereof and of all obligations of the hospital;

(b) deposit in his name, as treasurer, in a bank approved by the state comptroller, all such moneys and transmit each month to the comptroller, and to the commissioner, a statement showing the amount received and deposited, from whom and for what received and when such deposits were made. Such statement of deposits shall be certified by the proper officer of the bank receiving such deposits. The treasurer shall make an affidavit to the effect that the sum so deposited is all the money received by him from any source of hospital income to the date of the last deposit appearing on such statement;

(c) pay out the money deposited for the proper uses of the hospital upon the voucher of the steward or business manager. Where the treasurer is a person other than the director, said voucher shall be countersigned by the director;

(d) keep full and accurate account of all receipts and payments in the manner and according to books and forms prescribed by the commissioner;

(e) balance all accounts on his books annually, for the preceding fiscal year, and make a statement thereof and an abstract of the receipts and payments for such year and transmit the same to the commissioner on or before the following fifteenth day of August;

(f) render an account of the state of the books and of the funds and property in his custody, whenever required by the commissioner; and,

(g) perform such other duties as the commissioner may require.

§ 455. Hospitals; special police officers; powers and duties. 1. The director of each hospital in the department may designate attendants or other employees to act as special police officers whose duty it shall be under the orders of the director to protect the grounds, buildings and patients of the hospital and to eject therefrom disorderly persons. Such attendants and employees, acting as special police officers, shall possess all the powers of peace officers, as set forth in section 2.20 of the criminal procedure law, on the grounds and premises.

2. The designation of such attendants and employees as special police officers in pursuance hereof, shall not be deemed to supersede, on the grounds and premises of such hospital, the authority of peace or police officers of the jurisdiction within which such hospital is located.

ARTICLE 4-A

REGULATION OF BODY PIERCING AND TATTOOING

Section 460. Definitions.

460-a. Restrictions on body piercing studios.

461. Permit required.

462. Application of article.

463. Denial of permit; notice of hearing.

464. Permits; display; renewal; duplicates.

465. Powers of the commissioner.

466. Judicial review.

467. Single use tattoo and body piercing equipment.

§ 460. Definitions. As used in this article, unless the context requires otherwise:

1. "Commissioner" shall mean the commissioner of health.

2. "Body piercing" shall mean the piercing of any part of the body, except the ear. Such term shall not include tongue-splitting, as defined

in section four hundred seventy of this chapter.

3. "Tattoo" shall mean a mark on the body of a person made with indelible ink or pigments injected beneath the outer layer of the skin.

4. "Body piercing specialist" shall mean any person who performs body piercing on the body of any other person.

5. "Tattooist" shall mean any person who applies a tattoo to the body of any other person.

6. "Body piercing studio" shall mean any premises in which the body piercing specialist conducts such practice.

7. "Tattoo studio" shall mean any premises in which the tattooist conducts such practice.

8. "Officer" shall mean the public official with primary responsibility for the enforcement of the state sanitary code within a county, or within a city with a population of one million or more persons. For purposes of this title an officer shall have the powers of a presiding officer under the state administrative procedure act within a county and shall have the powers of a presiding officer under the city administrative procedures act within a city with a population of one million or more persons.

9. "Department" shall mean the department of health.

10. "Approved ink handling procedure" shall mean tattoo ink storage and use procedures that are approved and deemed protective by the department.

11. "Single use needle" shall mean a needle that is sterile and that has never been used on another person.

§ 460-a. Restrictions on body piercing studios. 1. No owner, operator

or employee of a body piercing studio shall permit body piercing on a person under eighteen years of age unless such person provides the body piercing studio with the written consent, in a form prescribed by the commissioner, of a parent or legal guardian to use such body piercing studio. The parent or legal guardian shall sign such consent form in the presence of the owner of the body piercing studio or a body piercing specialist of such studio. Such original written consent shall be retained by the body piercing studio for a period of twelve months and may be retained off premises provided that an electronic image or facsimile of the original signed consent form is readily available by the owner or employee responsible for the operation of the body piercing studio.

2. A written consent form signed by a parent or legal guardian pursuant to subdivision one of this section shall expire twelve months from the date it is signed by the parent or legal guardian. Upon the expiration of a written consent form, a new written consent shall be provided in the manner prescribed in subdivision one of this section prior to the use of a body piercing studio by any person under eighteen years of age.

3. This section shall be exclusive and shall preempt any contrary local law or ordinance, except that this section shall not preempt or supersede local laws or ordinances imposing additional stricter restrictions on the operation of body piercing studios which are in effect prior to the effective date of this section.

§ 461. Permit required. 1. No person shall be a body piercing specialist or tattooist and no person, firm, corporation, partnership, or other association shall operate a body piercing studio or tattoo studio without first obtaining a permit from the department.

2. All body piercing or tattooing shall be performed in accordance with the rules and regulations promulgated by the commissioner pursuant to the public health law.

3. The department shall issue a permit if the body piercing specialist and body piercing studio or tattooist and tattoo studio are in compliance with this article, the penal law and the state sanitary code and are not otherwise disqualified under this article.

§ 462. Application of article. 1. This article shall not apply to or affect a physician duly licensed under article one hundred thirty-one of the education law or x-ray technicians.

2. This article shall not apply to, affect, or restrict the ability of a city, town, village, or county to enact a local law or ordinance prohibiting or restricting body piercing or tattooing within such city, town, village or county.

3. Nothing contained in this article shall be construed to limit the duty or power of an officer to act with regard to an immediate threat to the health of the customers of a body piercing specialist or tattooist or body piercing studio or tattoo studio or the community in which it is located, or to alter or abridge any of the duties and powers now or hereafter existing in the commissioner, state district health officers, county boards of health, county commissioners of health or local boards of health.

§ 463. Denial of permit; notice of hearing. The department shall, before making a final determination to deny an application for a permit, notify the applicant in writing of the reasons for such proposed denial and shall afford the applicant an opportunity to be heard in person or by counsel prior to denial of the application. Such notification shall be served personally or by certified mail or in any manner authorized by the civil practice law and rules for service of a summons. If a hearing is requested, such hearing shall be held at such time and place as the department shall prescribe. If the applicant fails to make a written request for a hearing within thirty days after receipt of such notification, then the notification of denial shall become the final determination of the department. The department, acting by such officer

as the commissioner may designate, shall have the power to subpoena and bring before the officer any person in this state, and administer an oath to and take testimony of any person or cause his deposition to be taken. A subpoena issued under this section shall be regulated by the civil practice law and rules. If, after such hearing, the application is denied, written notice of such denial shall be served upon the applicant personally or by certified mail or in any manner authorized by the civil practice law and rules for the service of a summons.

§ 464. Permits; display; renewal; duplicates. 1. All permits shall be for a period of two years.

2. No permit shall be assignable or transferable.

3. Each permit issued pursuant to this article shall be posted and kept posted in some conspicuous place in the body piercing studio or tattoo studio in which the permittee is engaged in the practice of body piercing or tattooing.

4. Any permit which has not been suspended or revoked, may, upon the payment of the renewal fee prescribed by the commissioner, be renewed for additional periods of two years from its expiration, upon the filing on any application for such renewal, on a form to be prescribed by the commissioner.

5. Any person, firm, corporation, partnership or other association failing to file application and fee for renewal of a permit within one year immediately following the expiration of his last permit shall pay an additional fee as prescribed by the commissioner.

6. A duplicate permit may be issued for one lost, destroyed or mutilated upon application therefor on a form prescribed by the commissioner and the payment of the fee prescribed therefor by the commissioner. Each such duplicate permit shall have the word "duplicate" stamped across the face thereof and shall bear the same number as the one it replaces.

§ 465. Powers of the commissioner. In addition to the powers and duties elsewhere prescribed in this article, the commissioner shall have power to:

1. Appoint one or more officers as shall be necessary to do or perform in the department's place or stead the acts authorized by this article;
2. Examine the qualifications and fitness of applicants for permits;
3. Keep records of all permits issued, suspended or revoked, or orders directing the cessation of unpermitted activities; and
4. Prepare a manual of rules and regulations for the conduct of examinations and to furnish copies thereof to persons desiring the same upon payment of a reasonable fee therefor.
5. Establish an appropriate fee structure for licenses, permits, renewals and duplicates, and set levels of punishments for failure to abide by this article.

§ 466. Judicial review. The action of the commissioner in suspending, revoking or refusing to issue or renew a permit or imposing any fine or reprimand upon the holder thereof may be reviewed by a proceeding brought under and pursuant to article seventy-eight of the civil practice law and rules.

§ 467. Single use tattoo and body piercing equipment.

1. All tattoo studios and body piercing studios shall use only single use needles and approved ink handling procedures in all tattoo and body piercing procedures performed in such establishments.
2. Prior to a person receiving a tattoo or body piercing from a

licensed tattooist or body piercing specialist, such person and licensed tattooist or body piercing specialist must sign a form confirming that the tattooist or body piercing specialist:

(a) Presented all single use needles in a sterile and sealed package, that are to be used during the tattoo or body piercing procedure, to the person receiving such tattoo or body piercing, and explained that only approved ink handling procedures would be used; and

(b) Opened all single use needles that are to be used during the tattoo or body piercing procedure in the presence of the person receiving such tattoo or body piercing.

3. A copy of the confirmation form shall be given to the person receiving a tattoo or body piercing. The tattoo studio or body piercing studio shall retain a copy of such confirmation form for a period not less than seven years.

4. The commissioner shall make regulations under this section.

ARTICLE 4-B **TONGUE-SPLITTING**

Section 470. Prohibition of tongue-splitting.

§ 470. Prohibition of tongue-splitting. 1. For the purposes of this section, "tongue-splitting" shall mean the cutting of a person's tongue into two or more parts.

2. No person shall perform a tongue-splitting on another person, unless the person performing such tongue-splitting is licensed to practice medicine pursuant to article one hundred thirty-one of the education law or licensed to practice dentistry pursuant to article one hundred thirty-three of the education law.

3. A violation of subdivision two of this section shall constitute a class A misdemeanor; provided, however, that a second or subsequent violation of such subdivision committed within five years of the date of

conviction for a prior offense shall constitute a class E felony.

ARTICLE 5

LABORATORIES

- Title I. General provisions: state laboratories; approved laboratories (§§ 500-506).
II. County laboratories (§§ 520-528).
III. City laboratories (§§ 540-545).
IV. Laboratory supply stations (§§ 560-563).
V. Clinical laboratory and blood banking services (§§ 570-581).
VI. Laboratory business practices (§§ 585-588).

TITLE I

GENERAL PROVISIONS: STATE LABORATORIES; APPROVED LABORATORIES

- Section 500. Wadsworth center for laboratories and research; establishment.
501. State laboratories; approved laboratories; powers and duties of commissioner.
502. Environmental laboratories; examinations; certificates of approval.
503. Laboratories; state hospitals; service to counties and municipalities.
504. Laboratories; scientific tests on living animals; rules; approval.
505. Animal irritancy tests prohibited.
505-a. Purchase of certain animals for scientific tests.
506. Unlawful interference with research laboratory operations.

§ 500. Wadsworth center for laboratories and research; establishment.

1. The commissioner shall establish and maintain one or more laboratories with such expert assistants and such facilities as are necessary for routine examinations and analyses, and for original investigations and research in matters affecting public health. The

laboratories shall be known as the Wadsworth center for laboratories and research.

2. The commissioner shall create within the Wadsworth center for laboratories and research a master of science degree program in the field of laboratory science, subject to approval of the board of regents and registration with the department of education.

§ 501. State laboratories; approved laboratories; powers and duties of commissioner. 1. The commissioner shall have authority:

(a) to make, at the expense of the state, examinations and analyses, at the request of any health officer or of any physician in accordance with the provisions of this article;

(b) to enter into contracts with laboratories in localities accessible to the various portions of the state for the prompt examination of specimens received from local health officers or physicians and for the immediate report thereon, at the expense of the state; provided that all such laboratories shall conform to the standards of efficiency established by the public health council, and that no obligation shall be incurred by the commissioner in excess of the sums available therefor.

§ 502. Environmental laboratories; examinations; certificates of approval. 1. For the purposes of this section, "environmental laboratory" is any facility that examines or is available for the examination of samples or specimens including, but not limited to: air, stack emissions, water, wastewater, surface water, ground water, recreational waters, swimming pools, leachate, land runoff, solid waste, hazardous waste, soil, sediments and vegetation, as well as any substance that could contribute to the pollution of or that could be contaminated by material contained in such samples or specimens. Such examinations shall be limited to the qualitative or quantitative determinations of the biological, chemical, radiochemical or physical characteristics of such samples or specimens for the purposes of public or personal health protection or the protection of the environment or

natural resources. Environmental laboratories shall not include non-laboratory chemical testing associated with residential water softeners and residential swimming pools.

2. No environmental laboratory may perform any examination on samples collected in the state of New York for which the commissioner issues a certificate of approval for such examination unless the laboratory has been issued such certificate of approval. Such laboratory examinations shall conform to any conditions under which the approval is granted.

3. The commissioner may issue to laboratories certificates of approval covering laboratory examinations, including but not limited to, specific procedures or specialties within such categories as wastewaters, potable waters, sediments, solid wastes, and air, and may prescribe the conditions under which such approvals will be granted. Notwithstanding any other conditions which he may prescribe, such an approval shall not be issued hereafter to a laboratory, not heretofore approved, unless the director or other person in charge of such examinations shall possess such educational and technical qualifications as the commissioner shall prescribe.

4. No state agency, authority, county, city, including the city of New York, town, village, water district, sewer district or other political subdivision of the state shall contract with any laboratory for laboratory examinations for which the commissioner issues certificates of approval pursuant to subdivision three of this section, unless such laboratory has been issued such certificate.

5. Subject to the approval of the director of the budget, the commissioner shall charge adequate and reasonable fees for the periodic inspection of out-of-state laboratories.

6. Subject to the approval of the director of the budget, the commissioner shall charge laboratories fees to recover the cost to the department of operating this program. The commissioner may waive all or any part of such fee charges for laboratories operated by the state. Fees shall include the following:

(a) a basic amount of five hundred dollars to be charged to each laboratory;

(b) the balance of the program cost from:

(1) an additional amount to be charged to each laboratory proportional to total adjusted volume of analytes performed by the laboratory in the preceding year as defined in regulations of the department, the total amount collected from which shall equal fifty percent of the balance of the program costs;

(2) an additional amount to be charged to each laboratory proportional to the number of analytes for which such laboratory maintains its certification.

Subparagraph one of paragraph (b) of this subdivision shall not apply to government laboratories.

7. For those categories, procedures or specialties as specified in subdivision three for which the commissioner has issued certificates of approval, the commissioner shall within thirty days of receipt of an application for a certificate from a laboratory existing on or before April first, nineteen hundred ninety-three, which is initially required to obtain certification, review such application and issue an interim certificate of approval in the particular category, procedure or speciality to all laboratories which provide adequate documentation in their application that they are capable of performing quality work in the category, procedure or speciality under review. An interim certificate of approval in specified categories will remain valid until such time as the commissioner shall reach a determination on the application.

8. The commissioner may adopt and amend rules and regulations to effectuate the provisions and purposes of this title.

9. A person who intentionally violates or refuses or omits to comply with subdivision two of this section, or any regulation adopted pursuant thereto, is guilty of a misdemeanor, punishable upon conviction, by imprisonment for not more than one year or by a fine of not more than one thousand dollars or by both such fine and imprisonment. A second or

subsequent conviction shall be punishable by imprisonment for not more than one year or a fine of not more than two thousand five hundred dollars or by both such fine and imprisonment.

10. The department may require an environmental laboratory to report laboratory test results to the department, or to any other health department in an electronic manner prescribed by the department.

§ 503. Laboratories; state hospitals; service to counties and municipalities. 1. The director of any hospital in the department, with the approval of the commissioner, may enter into a contract with proper municipal or county officials under which the laboratory service of the hospital may be made available to municipalities or counties or parts thereof when in his judgment such a contract shall be in the interest of public health and not prejudicial to the interest or work of the institution.

2. The treasurer of the hospital, or the director thereof, if there is no treasurer, shall receive all moneys paid in consideration of such contract and pay the same into the general fund of the state.

§ 504. Laboratories; scientific tests on living animals; rules; approval. 1. The commissioner is authorized to designate approved laboratories or institutions wherein properly conducted scientific tests, experiments or investigations, involving the use of living animals, may be performed or conducted.

2. (a) The commissioner shall promulgate rules under which such approvals shall be granted, and shall cause such rules to be published, and copies thereof shall be conspicuously posted in each such laboratory or institution.

(b) Such rules of the commissioner shall include requirements that all animals shall be kindly and humanely treated, properly fed and suitably housed, and that commensurate with experimental needs and with the physiologic function under study, all tests, experiments and

investigations involving pain shall be performed under adequate anesthesia.

3. The commissioner or his duly authorized representative shall inspect such laboratories or institutions to insure compliance with the rules and standards promulgated by him.

4. (a) The approval of a laboratory or institution by the commissioner for the purposes herein set forth shall be limited to a period not exceeding one year but may be renewed from year to year upon proper application to the commissioner.

(b) Each such approval may be revoked at any time for failure to comply with the rules promulgated by the commissioner.

5. The performance of animal experimentation without approval by the commissioner as herein provided shall constitute a misdemeanor.

§ 505. Animal irritancy tests prohibited. 1. No manufacturer or contract testing facilities shall conduct traditional animal test methods within this state for which an appropriate alternative test method has been scientifically validated and recommended by the Inter-Agency Coordinating Committee for the Validation of Alternative Methods (ICCVAM) and adopted by the regulation by the relevant federal agency or agencies or program within an agency responsible for regulating the specific product or activity for which the test is being conducted.

2. Nothing in this section shall prohibit the conduct of any alternative nonanimal test method for the testing of any product, product formulation, chemical, or ingredient that is not recommended by ICCVAM.

3. Nothing in this section shall prohibit the conduct of animal tests to comply with the requirements of state agencies. Nothing in this section shall prohibit the conduct of animal tests to comply with the requirements of federal agencies whenever the federal agency staff

concludes that the alternative nonanimal test does not assure the health or safety of consumers.

4. Notwithstanding any other provision of law, the exclusive remedy for enforcing this section shall be a civil action for injunctive relief brought by the attorney general. If the court determines that the attorney general is the prevailing party in the enforcement action, such prevailing party may also recover costs, attorneys fees and a civil penalty not to exceed one thousand dollars in that action.

5. This section shall not apply to any animal test conducted for the purpose of medical research.

6. For the purposes of this section, the following terms shall have the following meanings:

(a) "Animal" means a vertebrate nonhuman animal.

(b) "Contract testing facility" means any individual, partnership, corporation, association, or other legal relationship that tests chemicals, ingredients, product formulations, or products in this state.

(c) "ICCVAM" means the Inter-Agency Coordinating Committee for the Validation of Alternative Methods, a federal committee comprised of representatives from fourteen federal regulatory or research agencies, including the Food and Drug Administration, Environmental Protection Agency, and Consumer Products Safety Commission, that reviews the validity of alternative test methods. The committee is the federal mechanism for recommending appropriate, valid test methods to relevant federal agencies.

(d) "Manufacturer" means any individual, partnership, corporation, association, or other legal relationship that produces chemicals, ingredients, product formulations, or products in this state.

(e) "Medical research" means research related to the causes, diagnosis, treatment, control or prevention of physical or mental diseases and impairments of humans and animals, or related to the development of biomedical products, devices or drugs as defined in Section 321(g)(1) of Title 21 of the United States Code. Medical research does not include the testing of an ingredient that was formerly used in a drug, tested for the drug use with traditional animal methods

to characterize the ingredient and to substantiate its safety for human use, and is now proposed for use in a product other than a biomedical product, medical device or drug.

(f) "Person" means any individual, partnership, corporation, association or other legal entity.

(g) "Traditional animal test method" means a process or procedure using animals to obtain information on the characteristics of a chemical or agent. Toxicological test methods generate information regarding the ability of a chemical or agent to product a specific biological effect under specified conditions.

(h) "Validated alternative test method" means a test method that does not use animals, or in some cases reduces or refines the current use of animals for which the reliability and relevance for a specific purpose has been established in validation studies as specified in the ICCVAM report provided to the relevant federal agencies.

§ 505-a. Purchase of certain animals for scientific tests. It shall be unlawful for any laboratory or institution approved under this article, to purchase any dog or cat for experimental purposes unless the seller thereof shall provide proof of ownership of the animal of a sufficiency prescribed by the commissioner. Every such laboratory or institution shall keep a record of each such purchase with the name and address of the seller and a copy of the proof of ownership given at the time of the transaction.

§ 506. Unlawful interference with research laboratory operations. An agency as defined in subdivision three of section eighty-six of the public officers law may deny access to records or portions thereof concerning biomedical research or biomedical teaching conducted at an institution of higher education authorized by the state education department or at an institution within the state that receives state or federal funding to conduct such biomedical research or such biomedical teaching that, if disclosed, could endanger the life or safety of any person or would be reasonably likely to endanger the security of such biomedical research laboratory.

TITLE II

COUNTY LABORATORIES

Section 520. County laboratories; establishment; charges.

521. County laboratories; establishment by referendum.

522. County laboratories; boards of supervisors; powers and duties.

523. County laboratories; boards of managers; appointment; term.

524. County laboratories; boards of managers; officers; meetings; compensation and expenses.

525. County laboratories; boards of managers; powers and duties.

526. County laboratories; annual reports.

527. County laboratories; director; powers and duties.

528. County laboratories; bills and accounts; payment.

§ 520. County laboratories; establishment; charges. 1. The board of supervisors of any county may establish therein a laboratory or laboratories which shall serve the whole or part of the county.

2. In the resolution of the board of supervisors establishing such laboratory it shall define the area which it is intended to serve, which area from time to time may by resolution be altered; provided, however, that in defining such area the territory included in a town shall not be divided and provided further, that no city or any part thereof shall be included in the area so defined unless the mayor and the common council, or the officials exercising similar powers, shall have consented thereto.

3. The services of such laboratories shall be rendered at an adequate and reasonable charge, except that, with the approval of the commissioner, one or more services may be rendered without any charge.

4. The board of supervisors may, in lieu of the establishment of a laboratory and with the approval of the commissioner, provide for laboratory service by contracting with an established laboratory which

is conveniently located.

§ 521. County laboratories; establishment by referendum. 1. Upon the petition signed by two hundred or more taxpayers of the county or district to be served by such a laboratory, the governing body of that county or district at the next date for filling an elective office shall hold a referendum upon the question of establishing a laboratory the construction of which is to be financed by taxes levied for the fiscal year in which the expenditures therefor are to be made. If a majority of the votes cast are in favor of establishing such a laboratory it shall be mandatory upon the governing body of that county or district to take the steps necessary for the establishment and maintenance of such a laboratory as provided for by this chapter.

2. Nothing contained in sections five hundred to five hundred twenty-one, inclusive, of this chapter shall be construed to prevent the financing of any expenditure, in whole or in part, pursuant to the local finance law.

§ 522. County laboratories; boards of supervisors; powers and duties.

1. The board of supervisors, when it shall have determined to establish a county laboratory, shall have the power:

(a) to acquire by purchase, exchange or otherwise, necessary real property, building or rooms or to erect necessary buildings;

(b) to cause to be assessed, levied and collected in the same manner as other charges against the county, such sums of money as it shall deem necessary for laboratory purposes; provided, however, that where a laboratory is intended to serve less than a whole county the expenditures made in connection therewith shall be assessed only against the area served by the laboratory; and

(c) to accept and hold in trust for the county any grant or devise of land or any gift or bequest of money or other personal property or any donation to be applied, principal or income, or both, for the benefit of said laboratory.

2. Nothing in this article shall be construed to repeal or amend any provision of law not inconsistent herewith relating to laboratories in counties or to abrogate any powers of boards of supervisors relating thereto.

§ 523. County laboratories; boards of managers; appointment; term. 1. The board of supervisors of a county establishing a laboratory pursuant to this article shall appoint a board of managers for the laboratory which shall consist of at least five members, two of whom shall be physicians duly licensed to practice in the state of New York.

2. The county medical society may present to the board of supervisors a list of physicians residing in the county from which the board may choose the medical members of the board of managers.

3. In counties having a county board of health and a county health commissioner, the president of the county board of health and the county health commissioner shall be members of the board of managers ex-officio.

4. The members of the board of managers, with the exception of the members ex-officio, shall first be appointed, so that the term of one member shall expire within one year from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within two years of the first day of January of the year in which he shall have been appointed, the term of another member shall expire within three years of the first day of January of the year in which he shall have been appointed, the term of another member shall expire within four years of the first day of January of the year in which he shall have been appointed, and the term of another member shall expire within five years of the first day of January of the year in which he shall have been appointed. Thereafter the terms of membership shall be made for five years from the first day of January of the year in which the appointment is made.

5. In any county in which a county health district has been or is

hereafter established, the boundaries of which are coterminous with the county, the board of supervisors shall have power to abolish the board of managers of the county laboratory, and confer all the powers and duties of such board of managers upon the county board of health.

6. The members of boards of managers in existence at the time when this chapter takes effect shall continue in office until their respective terms have expired and their respective successors are appointed and have qualified.

7. (a) The county laboratory board of managers in any county wherein an alternative form of government shall have established a county health district coterminous with the county is hereby abolished and the laboratory transferred and reestablished as a division of the county health department.

(b) The county may thereafter apply for state aid for such laboratory and shall be entitled to such state aid as would be provided under this section if the amount expended for maintenance and operation of such laboratory were expended for maintenance and operation of a laboratory established in accordance with other provisions of this chapter.

§ 524. County laboratories; boards of managers; officers; meetings; compensation and expenses. 1. Except in counties wherein the laboratory functions as a division of the county health department or wherein the board of managers has been abolished, the board of managers of each laboratory shall elect a chairman, vice chairman and a secretary.

2. The board of managers of each laboratory shall hold a meeting at least four times in each year, and at such other times as it may deem necessary.

3. Each member of the board of managers attending meetings of such board shall receive his actual and necessary expenses incident thereto, to be audited and paid in the same manner as other expenses of the laboratory.

4. Nothing contained in this section shall be construed to effect any change in the administration and organization of a county board of health which shall be vested with the powers and duties of a board of managers pursuant to subdivision five of section five hundred twenty-three of this chapter.

§ 525. County laboratories; boards of managers; powers and duties. The board of managers of each laboratory, or the county board of health in any county wherein an alternative form of government shall have established a county health district coterminous with the county, subject to the provisions of the county government law of such county, or a county board of health which has been vested with the powers and duties of a board of managers pursuant to subdivision five of section five hundred twenty-three of this chapter, shall have the following powers and duties:

(a) to appoint a director or other person in charge of the laboratory who shall have such qualifications as may be prescribed by the public health council;

(b) to exercise general management and control of the laboratory, of the grounds, buildings, rooms, employees and of all other matters relating to the government, discipline, contracts and fiscal concerns thereof;

(c) to make such rules and regulations as may be necessary in relation to the administration of the laboratory and the fees to be charged for laboratory service, not inconsistent with the provisions of this chapter;

(d) notwithstanding any other general or special law, to cause to be erected all additional buildings found necessary after the laboratory has been placed in operation and to cause to be made all necessary improvements and repairs within the limits of the appropriations made therefor; and,

(e) to establish branch laboratories if the area to be served by the laboratory is so large, if its topography is such as to make access to the laboratory difficult, or if for any other reason such action seems reasonable or desirable.

(f) to enter into an agreement annually with the governing board of

any charitable corporation or municipality operating and maintaining a hospital to provide that the hospital collect fees for laboratory services for the patients in such hospital in the same manner that hospital charges are collected, and forward them to the laboratory, and to provide that the cost of collecting such fees to be paid by the county to the hospital in an amount mutually acceptable and in lieu of actual and necessary expenses. No agreement shall become effective unless and until approved by the commissioner and by resolution of the board of supervisors.

§ 526. County laboratories; annual reports. 1. Except in counties wherein the laboratory has been transferred and established as a division of the county health department, the board of managers of each laboratory, or the county board of health which has been vested with the powers and duties of a board of managers pursuant to subdivision five of section five hundred twenty-three of this chapter, shall make to the board of supervisors annually at such time as said supervisors shall direct a detailed report of the operation of the laboratory during the calendar year, including among other things, the number and kind of specimens examined and the results of such examinations, together with suitable recommendations and such other matters as may be required of them.

2. In counties wherein the laboratory has been transferred and established as a division of the county health department pursuant to law the county board of health shall make to the county executive annually such report at such time as said county executive shall direct a detailed report of the operation of the laboratory during the calendar year, including among other things, the number and kind of specimens examined and the results of such examinations.

§ 527. County laboratories; director; powers and duties. 1. Except as provided in subdivision two of this section, the director or other person in charge of each county laboratory, subject to the approval of the board of managers, shall:

(a) equip the laboratory with all necessary furniture, appliances, fixtures and other needed facilities for the conduct of laboratory work and purchase all necessary supplies within the appropriations made therefor;

(b) have general supervision and control of the internal affairs and work of the laboratory;

(c) make and enforce such rules, regulations and orders as he may deem necessary, not inconsistent with law or with the rules and regulations of the board of managers, or of the county board of health, whichever is the governing authority;

(d) unless otherwise provided by law appoint employees of the laboratory within the limits of his appropriations, and remove them;

(e) cause to be kept proper accounts and records of the business and operation of the laboratory, including such records relating to specimens examined and render such reports as may be required by law or by the regulations of the commissioner.

2. The director or other person in charge of each county laboratory in any county wherein an alternative form of government shall have established a county health district coterminous with the county and in which the laboratory has been transferred and reestablished as a division of the county health department, subject to the approval of the county board of health and the provisions of the county government law of such county, shall:

(a) have general supervision and control of the internal affairs and work of the laboratory;

(b) make and enforce such rules, regulations and orders as he may deem necessary, not inconsistent with law or with the rules and regulations of the board of health;

(c) recommend to the board of health appointment of employees for the laboratory and the acquisition of equipment, furniture, appliances, fixtures and other needed facilities for the conduct of the work of the laboratory;

(d) cause to be kept proper accounts and records of the business and operation of the laboratory, including such records relating to specimens examined and render such reports as may be required by law or by the regulations of the commissioner.

§ 528. County laboratories; bills and accounts; payment. 1. Unless otherwise provided by law, the director or other person in charge of each laboratory shall certify all bills and accounts including salaries and wages, and transmit them to the board of supervisors of the county which shall provide for their payment in the same manner as other charges against the county.

2. The board of supervisors of a county not having a purchasing agent may make an appropriation for the maintenance of such laboratory and direct the county treasurer to pay all bills, accounts, salaries and wages which are approved by the director of the laboratory within the amount of such appropriation, subject to such regulations as to the payment and audit thereof as the board of supervisors may deem proper.

TITLE III

CITY LABORATORIES

Section 540. City laboratories; continuation and establishment.

541. City laboratories; operation and control.

542. City laboratories; boards of managers; appointment.

543. City laboratories; board of managers; power to enter into agreements with hospitals.

545. City of New York; exceptions.

§ 540. City laboratories; continuation and establishment. 1. (a) Nothing contained in sections five hundred twenty-five to five hundred twenty-eight, inclusive, of this chapter, shall be construed to repeal or amend any provision of law under which any health function or activity may be carried on in any city, or to transfer or affect any authority in relation to health activities now being exercised in any city by any public board or officer.

(b) Any public board or officer of a city now exercising health functions may, with the approval of the mayor, contract with the board of managers or other governing authority of any laboratory for the

purpose of cooperation and to join and share facilities.

2. If it is the intention of the common council or similar authority of a city to apply for state aid for a proposed laboratory, under the provisions of section six hundred twenty to six hundred twenty-three, inclusive, of this chapter, the common council or similar authority with the approval of the board of estimate, if such exists, shall have the power to establish a laboratory in such city.

§ 541. City laboratories; operation and control. 1. Upon the establishment or continuation of a laboratory by a city as provided in section five hundred forty of this chapter, all the powers and duties of the board of supervisors of a county in relation to laboratories provided in sections five hundred twenty and five hundred twenty-two of this chapter, shall devolve upon the common council or other authority exercising similar powers of such city.

2. The salaries of the director and other employees of the laboratory, and contracts to be made for, by or on behalf of the laboratory and appropriations for the acquisition of sites and buildings and for maintenance, shall all be under the control of the same officials as now have control of similar items and shall be governed by the same provisions of law.

§ 542. City laboratories; boards of managers; appointment. 1. (a) The mayor of any city establishing a laboratory in accordance with the provisions of this article shall appoint the board of managers of such laboratory which board shall consist of at least five members, two of them shall be physicians duly licensed to practice in the state of New York. The county medical society may present to the mayor a list of names of physicians residing in the city from which he may choose the medical members of the board of managers.

(d) The president of the local board of health, if such office exists, and the local commissioner of health or health officer shall be ex-officio members of the board of managers of the laboratory.

2. In cities when more than one laboratory is established, only one board of managers shall be appointed, which shall have jurisdiction over all the laboratories established or operating under sections five hundred forty to five hundred forty-three inclusive, of this chapter, in said city.

§ 543. City laboratories; board of managers; power to enter into agreements with hospitals. The board of managers of a city laboratory shall have the power to enter into an agreement annually with the governing board of any charitable corporation or municipality operating and maintaining a hospital to provide that the hospital collect fees for laboratory services for the patients in such hospital in the same manner that hospital charges are collected, and forward them to the laboratory, and to provide that the cost of collecting such fees be paid by the city to the hospital in an amount mutually acceptable and in lieu of actual and necessary expenses. No agreement shall become effective unless and until approved by the commissioner and by resolution of the common council or other body exercising similar powers.

§ 545. City of New York; exceptions. Unless otherwise expressly provided, the provisions of sections five hundred forty to five hundred forty-four of this chapter, inclusive, shall not apply to the city of New York.

TITLE IV

LABORATORY SUPPLY STATIONS

Section 560. Laboratory supply stations; districts; establishment.

561. Laboratory supply stations; custodian; appointment.

562. Laboratory supply stations; expenses.

563. Laboratory supply stations; control; inspection;
discontinuance.

§ 560. Laboratory supply stations; districts; establishment. 1. The commissioner or his authorized representative may establish district laboratory supply stations, for the distribution of laboratory supplies furnished by the department.

2. The commissioner may designate districts to be served by such district laboratory supply stations, each such district to include one or more municipalities provided, however, that no such district shall include the whole or part of more than one county.

§ 561. Laboratory supply stations; custodian; appointment. The commissioner may appoint the health officer of any municipality or county, the director or person in charge of any public health laboratory, or other competent person, to serve as the custodian of the district laboratory supply station.

§ 562. Laboratory supply stations; expenses. The actual and necessary expenses of operation and maintenance of the district laboratory supply station and sub-stations shall be paid in the manner prescribed for the payment of other bills of the municipality or county. All such sums shall be a charge upon the municipality, when a single municipality is included in a district, and, upon the county when more than one municipality is included, to be paid from amounts appropriated by the municipality or county for laboratory services or general public health purposes.

§ 563. Laboratory supply stations; control; inspection; discontinuance. 1. Each district laboratory supply station and the sub-stations thereof shall be maintained and operated in accordance with the rules and regulations of the department and shall be subject at all times to inspection by authorized representatives of the commissioner.

2. The commissioner may at any time discontinue any district laboratory supply station or sub-station or rescind any appointment

previously made under this chapter.

TITLE V

CLINICAL LABORATORY AND BLOOD BANKING SERVICES

- Section 570. Declaration of policy and statement of purpose.
571. Definitions.
572. Certificates of qualification.
573. Issuance of certificates of qualification.
574. Permits.
575. Issuance of permits.
- 575-a. Source plasma donation centers.
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- 576-a. Clinical laboratories and cytotechnologists examining Pap smears.
- 576-b. Performance of certain clinical laboratory services upon request.
- 576-c. Electronic reporting of disease and specimen submission.
577. Enforcement.
578. Penalties.
579. Scope and exceptions.
580. Construction.
581. Separability.

§ 570. Declaration of policy and statement of purpose. The proper performance of clinical laboratory and blood banking services is a matter of vital concern, affecting the public health, safety and welfare. Clinical laboratories and blood banks provide essential public health services in aiding the health care provider by furnishing information invaluable to the diagnosis and treatment of disease. The improper performance of a laboratory procedure may induce an erroneous diagnosis or contribute to the selection of an inappropriate method of treatment, resulting in prolonged or unnecessary hospitalization, injury or even death. The protection of the people of this state requires affirmative action to insure that the performance of clinical laboratory and blood banking services meet high standards of public health care.

It is the purpose of this title to promote the public health, safety and welfare by requiring the licensure of clinical laboratories and blood banks, by establishing minimum qualifications for directors, and by requiring that the performance of all procedures employed by clinical laboratories and blood banks meet minimum standards accepted and approved by the department.

§ 571. Definitions. As used in this title:

1. "Clinical laboratory" means a facility for the microbiological, immunological, chemical, hematological, biophysical, cytological, pathological, genetic, or other examination of materials derived from the human body, for the purpose of obtaining information for the diagnosis, prevention, or treatment of disease or the assessment of a health condition or for identification purposes. Such examinations shall include procedures to determine, measure or otherwise describe the presence or absence of various substances, components or organisms in the human body. The term clinical laboratory shall not include any facility or activity specifically excluded by section five hundred seventy-nine of this title.

2. "Blood bank" means a facility for the collection, processing, storage and/or distribution of human blood, blood components or blood derivatives, but shall not mean a source plasma donation center.

2-a. "Source plasma donation center" means a facility where source plasma is collected by plasmapheresis. "Source plasma" means the fluid portion of human blood collected by plasmapheresis and intended as source material for plasma protein therapies. "Source plasma donation center" shall not include single donor plasma products intended for intravenous use.

2-b. "Plasmapheresis" means a procedure by which, during a single visit to the facility, blood is removed from an individual, the source plasma separated from the formed elements, and at least the red blood

cells are returned to the donor.

3. "Reference system" means a system of assessment of methods, procedures and materials of clinical laboratories and blood banks, including, but not limited to, ongoing validation which may include direct testing and experimentation by the department of such methods, procedures and materials, the distribution of standards and guidelines, inspection of facilities, periodic submission of test specimens for examination, and research conducted by the department that involves the study of new or existing methods, procedures and materials related to the quality of clinical laboratory medicine.

4. "Director" means the person who is responsible for administration of the technical and scientific operation of a clinical laboratory or blood bank, including supervision of procedures and reporting of findings of tests.

5. "Waived test" means a clinical laboratory test that has been designated as a waived test or is otherwise subject to certificate of waiver requirements pursuant to the federal clinical laboratory improvement act of nineteen hundred eighty-eight, as amended.

* 6. "Qualified health care professional" means a physician, dentist, podiatrist, optometrist performing a clinical laboratory test that does not use an invasive modality as defined in section seventy-one hundred one of the education law, pharmacist administering COVID-19 and influenza tests pursuant to subdivision seven of section sixty-eight hundred one of the education law, physician assistant, specialist assistant, nurse practitioner, or midwife, who is licensed and registered with the state education department.

* NB Effective until July 1, 2030

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

* NB Effective July 1, 2030

7. "Provider-performed microscopy procedure" means a procedure performed by a qualified health care professional acting within the scope of his or her licensed profession, which has been designated as a provider-performed microscopy procedure pursuant to the federal clinical laboratory improvement act of nineteen hundred eighty-eight, as amended.

8. "Laboratory test registrant" means a person, partnership, corporation, or other entity holding a valid certificate of registration to perform one or more waived tests or provider-performed microscopy procedures pursuant to section five hundred seventy-nine of this title.

§ 572. Certificates of qualification. No person shall act as a director in a clinical laboratory located in or accepting specimens from New York state or in a blood bank located in or collecting, processing, storing or distributing blood products in New York state unless a valid certificate of qualification has been issued as provided in section five hundred seventy-three of this title.

§ 573. Issuance of certificates of qualification. 1. The department shall issue a certificate of qualification to any person who meets minimum qualifications, prescribed by the department and in accordance with federal regulations, including board certification as required, and who otherwise demonstrates to the department that such person possesses the character, competence, training and ability to administer properly the technical and scientific operation of a clinical laboratory or blood bank, including supervision of procedures and reporting of findings of tests.

2. Application for a certificate of qualification shall be made on forms provided by the department and such other information as the department may require.

3. The certificate shall be valid for a period of two years from the date of issuance and may be renewed for successive two-year periods

thereafter. The original application and each renewal application shall be accompanied by a registration fee of one hundred fifty dollars.

4. Notwithstanding the provisions of this section, the commissioner may issue a temporary certificate of qualification to any person pending the issuance of a certificate as provided in this section. A temporary certificate shall be valid for a period of thirty days from the date of its issuance and may be renewed for a maximum of four successive periods of thirty days.

§ 574. Permits. No person shall own or operate a clinical laboratory located in or accepting specimens from New York state or own or operate a blood bank which collects, processes, stores and/or distributes, human blood, blood derivatives or blood components, in New York state unless a valid permit has been issued as provided in section five hundred seventy-five of this title. A permit shall be issued authorizing the performance of one or more procedures or services within one or more categories. A separate permit shall be required for each facility at which clinical laboratory tests are to be performed or at which a blood bank is to be operated, provided, however that the department may adopt regulations not inconsistent with the federal clinical laboratory improvement act of nineteen hundred eighty-eight authorizing an owner to operate more than one facility under a single permit.

§ 575. Issuance of permits. 1. Application for a permit shall be made by the owner and the director of the clinical laboratory or blood bank in a manner and format prescribed by the department. The application shall contain the name of the owner, the name of the director, the procedures or categories of procedures or services for which the permit is sought, the location or locations and physical description of the facility or location or locations at which tests are to be performed or at which a blood bank is to be operated, and such other information as the department may require.

2. A permit shall not be issued unless a valid certificate of

qualification has been issued pursuant to the provisions of section five hundred seventy-three of this title, unless all fees and outstanding penalties, if any, have been paid, and the department finds that the clinical laboratory or blood bank is competently staffed and properly equipped, and will be operated in the manner required by this title.

3. The permit shall be issued jointly to the owner and the director and they jointly and severally shall be responsible to the department for the maintenance and operation of the clinical laboratory or blood bank and for any violations of this title and the rules and regulations promulgated thereunder.

4. A permit shall be valid for the year for which it is issued. The initial application for a permit shall be accompanied by a registration fee of one hundred dollars.

5. The permit shall specify the names of the owners and the director, the procedures or categories of procedures or services authorized, and the locations at which such procedures or services may be performed. The permit and the certificate of qualification shall be displayed at all times in a prominent place in the laboratory.

6. A permit shall become void by a change in the director, owner, or location. A category on a permit shall become void by a change in the director for that category. The department may, pursuant to regulations adopted under this title, extend the date on which a permit or category on a permit shall become void for a period not to exceed sixty days from the date of a change of the director, owner or location. An application for a new permit must be made in the manner provided by this section.

§ 575-a. Source plasma donation centers. 1. Notwithstanding section five hundred seventy-four and subdivision one of section five hundred seventy-one of this chapter, a source plasma donation center may collect source plasma through plasmapheresis, and may employ a person to perform total protein tests using digital refractometers, and to perform hematocrit tests, if the source plasma donation center and such person

comply with all the requirements of federal law and regulations governing the collection of source plasma, including, but not limited to, laws governing staff supervision, training, and duties, including requirements for performing total protein tests using digital refractometers in a source plasma donation center.

2. The commissioner may make reasonable additional regulations governing source plasma donation centers, including requirements for registration as a source plasma donation center and payment of a reasonable registration fee. Rules and regulations applicable to source plasma donation centers shall be consistent with this section.

§ 576. Duties and powers of the department. 1. The department may inquire into the operation of clinical laboratories and blood banks and may conduct periodic inspections and/or evaluations of facilities, methods, procedures, materials, staff and equipment to assess compliance with requirements set forth in this title, the regulations promulgated hereunder and local laws, codes or regulations as specified in subdivision three of section five hundred eighty of this title.

2. The department may require clinical laboratories and blood banks to submit, in a form prescribed by the department, periodic reports of tests performed and such other information as the department may require to carry out the provisions of this title. The department may adopt regulations to require clinical laboratories and blood banks to report all serious adverse incidents which may be connected to the clinical laboratory or blood bank services provided. Such incident reports shall be deemed confidential in the same manner as such reports submitted pursuant to section twenty-eight hundred five-m of this chapter. The department may also require clinical laboratories and blood banks to submit lists of personnel who are employed to perform laboratory procedures and to notify the department promptly of any changes in such personnel.

3. The department shall operate a reference system and shall prescribe standards for the proper operation of clinical laboratories and blood

banks and for the examination of specimens. As part of such reference system, the department may review and approve testing methods developed or modified by clinical laboratories and blood banks prior to the testing methods being offered in this state, and may require clinical laboratories and blood banks to analyze test samples submitted by the department and to report on the results of such analyses. The rules and regulations of the department shall prescribe the requirements for the proper operation of a clinical laboratory or blood bank, for the approval of methods and the manner in which proficiency testing or analyses of samples shall be performed and reports submitted. Failure to meet department standards for the proper operation of a clinical laboratory or blood bank, including the criteria for approval of methods, or failure to maintain satisfactory performance in proficiency testing shall result in termination of the permit in the category or categories of testing established by the department in regulation until remediation is achieved. Such standards shall be at least as stringent as federal standards promulgated under the federal clinical laboratory improvement amendments of nineteen hundred eighty-eight. Such failure and termination shall be subject to review in accordance with regulations adopted by the department.

4. (a) The department may adopt and amend rules and regulations to effectuate the provisions and purposes of this title. Such rules and regulations shall establish fees for clinical laboratories and blood banks in amounts not exceeding the cost of the reference system for clinical laboratories and blood banks and shall be subject to the approval of the director of the budget. For the purposes of this subdivision, standard federally established governmental cost allocation practices shall be used by the commissioner to determine the cost of the reference system. The department shall make available, on the department's website, information on the costs included in determining the permitted laboratories' fees. The department shall not deem as costs of the reference system, costs associated with federal grants and patents which are not related to the reference system. The fee paid by the department to maintain an exemption for clinical laboratories and blood banks from the requirements of the federal clinical laboratory improvement amendments of nineteen hundred eighty-eight shall be deemed

a cost of the reference system.

(b) In determining the fee charges to be assessed, the department shall, on or before May first of each year, compute the costs for the preceding state fiscal year which were expended to operate and administer the duties of the department pursuant to this title. The department shall, at such time or times and pursuant to such procedure as it shall determine by regulation, bill and collect from each clinical laboratory and blood bank an amount computed by multiplying such total computed operating expenses of the department by a fraction the numerator of which is the gross annual receipts of such clinical laboratory or blood bank during such twelve month period preceding the date of computation as the department shall designate by regulation, and the denominator of which is the total gross annual receipts of all clinical laboratories or blood banks operating in the state during such period.

(c) Each such clinical laboratory and blood bank shall submit to the department, in such form and at such times as the department may require, a report containing information regarding its gross annual receipts for all activities performed pursuant to a permit issued by the department in accordance with the provisions of section five hundred seventy-five of this title. The department may require additional information and audit and review such information to verify its accuracy.

(d) Partial payments equal to one-quarter of the total amount billed, may be made on or before June thirtieth, September thirtieth, December thirty-first and March tenth of the fiscal year to which the billing relates.

(e) On or before September fifteenth of each year, the department shall reconcile its costs and expenses for the reference system for the preceding state fiscal year and shall, on or before October fifteenth send to each clinical laboratory and blood bank, a statement setting forth the amount due and payable by, or the amount computed to the credit of, such clinical laboratory or blood bank, computed on the basis of the above stated formula, except that for the purposes of such computation the fraction shall be multiplied against the total recomputed expenses of the department for such fiscal year. Any amount due shall be payable not later than thirty days following the date of

such statement. Any credit shall be applied against any succeeding payment due.

(f) The commissioner may waive all or any part of such fee charges for clinical laboratories or blood banks operated by local governments and for nonprofit clinical laboratories or blood banks performing examinations and analyses or providing services under contract with the state or its local governments.

(g) Subject to the approval of the director of the budget, the commissioner shall charge adequate and reasonable fees for the periodic inspection of out-of-state clinical laboratories and blood banks, not exceeding the estimated additional costs incurred for out-of-state inspections under this title.

5. The department, within the amounts appropriated, may employ inspectors, investigators, assistants and other employees or may contract with the city of New York to carry out the provisions of this title, set the compensation of such employees, within limits provided by law, and prescribe the duties of such employees.

6. The commissioner may appoint one or more advisory committees of persons expert in the major categories of clinical laboratory procedures to advise the commissioner in connection with the qualifications of technical personnel employed and the use of appropriate procedures. Each such advisory committee shall include at least one designee of the commissioner of the department of health of the city of New York.

7. The department may adopt rules or regulations applicable only to or in the city of New York which are designed to address special needs or circumstances existing in such city. The department shall consider the recommendations of the city of New York, or the department or board of health of such city, concerning the adoption or amendment of any such rules or regulations.

8. The department may enter into agreements with the secretary of health and human services as authorized by the federal clinical laboratory improvement act of nineteen hundred eighty-eight and title XVIII of the social security act to perform such acts as may be

necessary to assure conformance with such laws by laboratories operating in the state.

§ 576-a. Clinical laboratories and cytotechnologists examining Pap smears. 1. Definitions. As used in this section, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(a) "Cytotechnologist". A clinical laboratory professional specializing in the analysis of cytopathology samples, including Pap smears, for cervical cancer and related diseases who meets the qualifications specified by the department.

(b) "Cytotechnologist work standard". (i) A limitation on the number of Pap smears (also known as gynecologic slides) and non-gynecologic slides a cytotechnologist may examine during a particular time period, or other limitation on the quantity, speed or manner of examination of slides by a cytotechnologist, under regulations of the department.

(ii) The department may establish regulations for cytotechnologist workload standards that shall be at least as stringent as federal regulations.

(c) "Employ". To employ or contract with a cytotechnologist to examine gynecologic slides.

(d) "Clinical laboratory". A clinical laboratory issued a permit pursuant to this title.

(e) "Work day". A twenty-four hour period during which a cytotechnologist examines gynecologic slides for a clinical laboratory.

2. Compliance with cytotechnologist work standard. No cytotechnologist shall exceed the applicable cytotechnologist work standard. No clinical laboratory shall require, authorize, encourage or permit any cytotechnologist to exceed the applicable cytotechnologist work standard. In determining whether a cytotechnologist exceeds the applicable cytotechnologist work standard, all work done by the cytotechnologist during a given work day shall be considered, without regard to which clinical laboratory or other person for which or whom it was performed.

3. Record-keeping. (a) Each clinical laboratory shall maintain records, in a form prescribed by the department, which set forth, for each cytotechnologist employed by the clinical laboratory:

(i) the name of the cytotechnologist;

(ii) the number of hours worked by the cytotechnologist in each work day;

(iii) the number of gynecologic slides and non-gynecologic slides examined by the cytotechnologist during each work day; and

(iv) such other information as the department may require by regulation.

(b) Such records of clinical laboratories and cytotechnologists shall be made available for inspection and copying by the department upon request.

4. Multiple employers. Whenever a cytotechnologist is employed by more than one clinical laboratory or other person during a work day, the cytotechnologist shall advise each clinical laboratory of any previous employment during the work day and the amount of work performed, to insure that the applicable cytotechnologist work standard is not exceeded.

5. Standards for gynecologic slides. (a) A gynecologic slide of a Pap smear shall not be tested or reported on if:

(i) the apparent condition of the specimen indicates that it is unsatisfactory for testing or that it is inappropriate for the test requested;

(ii) it has been collected, labeled, preserved or otherwise handled in such a manner that it has become unsatisfactory or unreliable as a test specimen;

(iii) the slide is broken;

(iv) it contains insufficient cells or the cells are obscured by inflammation, blood or lubricating ointment, so that an adequate diagnosis cannot be made; or

(v) the slide is otherwise unsatisfactory, as defined by department regulations.

(b) If the slide is unsatisfactory as set forth in this subdivision, the clinical laboratory shall have an affirmative duty to advise the

collecting physician or other practitioner that the slide is unsatisfactory and request the submission of a new slide.

6. Re-examination of slides. The department shall prescribe, by regulation, a system of targeted re-examination of gynecologic slides examined and found to be not abnormal or questionable. The factors to be considered in the targeted re-examination may include, but are not limited to, the prior cancer and other history of the patient, the results of previous slide examinations, and the experience and ability of the cytotechnologist. Each clinical laboratory shall follow the prescribed re-examination system.

7. Notwithstanding any provisions of subdivision one of this section to the contrary, the department may, pursuant to regulation, increase the maximum number of slides which may be examined in a work day for clinical laboratories using slide examination or preparation technology approved by the federal food and drug administration, provided that such standards shall be at least as stringent as federal standards promulgated under the federal clinical laboratory improvement amendments of nineteen hundred eighty-eight or other applicable federal law.

8. Violations. (a) Sections twelve, twelve-a, and twelve-b of this chapter shall apply to violations of this section, except that the civil penalty for a violation of this section by a cytotechnologist shall not exceed five hundred dollars.

(b) If any clinical laboratory or other person violating this section is licensed, certified or registered by the department under other provisions of law, the violation of this section may be grounds for disciplining the person under such law.

§ 576-b. Performance of certain clinical laboratory services upon request. 1. A clinical laboratory may perform a clinical laboratory service (including accepting a specimen or assignment for examination and rendering a report), that it is otherwise allowed to perform, upon the request of the person on whom the service is to be performed and render a report directly to the person, where the service is for the

same purpose as a test or collection device that has been approved or cleared by the Food and Drug Administration of the United States Department of Health and Human Services for sale or distribution to the public on a direct or over-the-counter basis without a prescription from a qualified health care practitioner.

2. All services conducted pursuant to this section shall comply with the standards for testing established by the department and with any other laws of this state, including requirements for confidentiality and pre-test and post-test counseling.

3. The results of any test conducted pursuant to this section shall be provided only to the person who requested the test. Such results shall be provided in a clear and concise manner that is understandable by lay persons and that identifies results indicating the need for referral to a physician or other qualified health care practitioner.

4. Nothing in this section shall authorize a clinical laboratory to engage in the practice of any health care profession under title eight of the education law. The report issued to a person for a test conducted pursuant to this section shall contain a clear statement, presented in a prominent manner, to the effect that the report should not be viewed as medical advice and is not meant to replace direct communication with a physician or other health care practitioner.

§ 576-c. Electronic reporting of disease and specimen submission. 1. Whenever a clinical laboratory or blood bank is otherwise required by this chapter to report evidence of a disease or health condition to the commissioner or a local health officer, the laboratory director shall report the test results and such data elements as are determined by the commissioner to be necessary as authorized by law. All reports shall be sent electronically to the department in a standards based electronic format, using a network, communications protocol, clinical syntax and vocabulary all as determined by the commissioner to be compatible with national health information standards promulgated by the federal centers for disease control and prevention and the department of health and

human services. Reports shall be submitted on a schedule determined by the commissioner.

2. Clinical laboratories and blood banks may continue to submit reports in paper copy to the commissioner and/or local health officer as otherwise required by this chapter until the earlier of the date the laboratory director receives notice that the laboratory has been certified to report electronically or one year after the effective date of this section. Thereafter, all reports shall be sent electronically to the department.

3. In the event the system for electronic reporting is unavailable for any reason, including lack of certification for electronic reporting, clinical laboratories and blood banks shall make reports to the local health officer of the county of the patient's residence and the commissioner using an alternate mechanism determined by the commissioner.

4. Whenever the commissioner or a local health officer determines that supplemental testing is necessary to confirm evidence of a disease or health condition otherwise required to be reported to the commissioner or a local health officer pursuant to this chapter, or to further identify the characteristics of a causative agent for reasons of public health protection, the laboratory shall submit all or part of the specimen or its derivatives with patient identifiers to the department or its designee, or the local health officer or his or her designee, in a manner and as directed by the commissioner.

5. The commissioner may adopt rules and regulations necessary to implement the provisions of this section.

§ 577. Enforcement. 1. A permit or certificate of qualification may be revoked, suspended, limited or annulled, or the holder thereof censured, reprimanded or otherwise disciplined by the department on proof that the certificate holder, owner or director, or one or more persons in his or her employ:

(a) has been guilty of misrepresentation in obtaining the permit or certificate or in the operation of the clinical laboratory or blood bank, including the submission to the department of proficiency test results obtained from another clinical laboratory;

(b) has knowingly accepted or permitted to be accepted a specimen or assignment for clinical laboratory examination from or rendered a report thereon to a person or persons not authorized by law to submit such assignment or specimen or receive such report;

(c) has engaged or attempted to engage or represented himself or herself as entitled to perform any procedure or category or procedures or services he or she is not authorized to perform;

(d) has rendered a report on work actually performed in another clinical laboratory or blood bank without designating the fact that the examination or procedure was performed in another clinical laboratory or blood bank;

(e) has demonstrated incompetence or shown consistent errors in performance of examinations or procedures;

(f) has failed to file any report required by the provisions of this title or the rules and regulations promulgated thereunder;

(g) has violated or aided and abetted in the violation of any provision of this chapter, including this title, title six of this article, or the rules and regulations promulgated pursuant to this chapter or a violation of title eleven of article five of the social services law or the rules and regulations promulgated thereunder related to laboratory services; or

(h) has violated or aided and abetted in the violation of local laws, codes or regulations as specified in subdivision three of section five hundred eighty of this title.

(i) has been found upon inspection by the department to be in noncompliance with a provision or provisions of this title or the rules and regulations promulgated hereunder, and has failed to address such findings as required by the department.

2. Proceedings under this section may be initiated by any person, corporation, association or public officer, or by the department, by filing written charges with the department.

3. No permit or certificate shall be revoked, suspended, limited or annulled without a hearing, except as provided in subdivision three of section five hundred seventy-six of this title. However, a permit or certificate may be temporarily suspended without a hearing for a period not to exceed thirty days upon notice to the permit or certificate holder following a finding by the department that the public health, safety or welfare is in imminent danger.

4. The commissioner shall set a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be mailed to the permit or certificate holder, at the address specified on the permit at least fifteen days before the date set for the hearing. The permit or certificate holder shall file with the department, not less than five days prior to the hearing, a written answer to the charges.

5. Any person or entity which owns or operates a clinical laboratory and who does not hold a valid laboratory permit shall be liable to the people of the state for a civil penalty not to exceed two thousand dollars for each day for the unauthorized operation of the clinical laboratory.

§ 578. Penalties. 1. (a) A person who owns or operates a clinical laboratory or blood bank, and who does not hold a valid permit issued pursuant to the provisions of this title or who otherwise does not comply with this title or the New York city health code is guilty of a misdemeanor, punishable by imprisonment for not more than one year, or by a fine of not more than two thousand dollars, or by both such fine and imprisonment. For any subsequent offense, the penalty shall be both such fine and imprisonment.

(b) A person who owns or operates a clinical laboratory or blood bank and willfully misreports laboratory results or otherwise fails to comply with the provisions of this title is guilty of a class A misdemeanor, punishable by imprisonment for not more than one year, or by a fine of not more than one thousand dollars, or by both such fine and imprisonment.

2. A person who acts as a director after July first, nineteen hundred sixty-five, and who does not hold a valid certificate of qualification issued pursuant to the provisions of this title is guilty of a misdemeanor, punishable by imprisonment for not more than one year, or by a fine of not more than five hundred dollars or by both such fine and imprisonment.

§ 579. Scope and exceptions. 1. This title is applicable to all clinical laboratories and blood banks operating within the state, except clinical laboratories and blood banks operated by the federal government and clinical laboratories operated by a licensed physician, osteopath, dentist, midwife, nurse practitioner, optometrist performing a clinical laboratory test that does not use an invasive modality as defined in section seventy-one hundred one of the education law or podiatrist who performs laboratory tests or procedures, personally or through his or her employees, solely as an adjunct to the treatment of his or her own patients; to the extent authorized by federal and state law, including the education law.

2. This title shall not be applicable to and the department shall not have the power to regulate pursuant to this title: (a) any examination performed by a state or local government of materials derived from the human body for use in criminal identification or as evidence in a criminal proceeding or for investigative purposes; (b) any test conducted pursuant to paragraph (c) of subdivision four of section eleven hundred ninety-four of the vehicle and traffic law and paragraph (c) of subdivision eight of section 25.24 of the parks, recreation and historic preservation law; (c) any examination performed by a state or local agency of materials derived from the body of an incarcerated individual, pretrial releasee, parolee, conditional releasee or probationer to (i) determine, measure or otherwise describe the presence or absence of any substance whose possession, ingestion or use is prohibited by law, the rules of the department of corrections and community supervision, the conditions of release established by the board of parole, the conditions of release established by a court or a

local conditional release commission or the conditions of any program to which such individuals are referred and (ii) to determine whether there has been a violation thereof; or (d) any examination performed by a coroner or medical examiner for the medical-legal investigation of a death. Nothing herein shall prevent the department from consulting with the division of criminal justice services, the department of corrections and community supervision, the state police, or any other state agency or commission, at the request of the division of criminal justice services, the department of corrections and community supervision, the state police, or such other agency or commission, concerning examination of materials for purposes other than public health.

3. (a) This title shall not be applicable to any person, partnership, corporation or other entity performing any waived test or provider-performed microscopy procedure, provided such person, partnership, corporation or other legal entity: (i) holds a valid certificate of registration issued by the department authorizing the performance of one or more waived tests or provider-performed microscopy procedures; and (ii) only performs tests authorized by the certificate of registration; and (iii) otherwise complies with all applicable requirements of this subdivision.

(b) The department may issue a certificate of registration authorizing the performance of one or more waived tests or provider-performed microscopy procedures for a period of up to two years if the applicant: (i) files a completed application with the department on such forms as the commissioner may prescribe; (ii) provides documentation acceptable to the department demonstrating the ability to comply with the requirements of this subdivision; and (iii) pays a two hundred dollar biennial registration fee for each location where services are rendered; except that a voluntary ambulance service as defined in article thirty of the public health law and operated under section two hundred nine-b of the general municipal law shall be exempt from the requirement to pay a fee to obtain this certificate of registration; and except that the following may operate multiple locations under a single registration and pay a single registration fee: (A) not-for-profit, state or local government laboratories or programs engaged in limited public health testing not exceeding fifteen types of tests per registration; or (B)

applicants that maintain a fixed location in the state and are approved by the department to move from testing site to testing site.

(c) Laboratory test registrants shall: (i) provide only the tests and services listed on the registration issued by the department hereunder; (ii) advise the department of any change in the registrant's name, ownership, location or qualified health care professional or laboratory director designated to supervise testing within thirty days of such change; (iii) provide the department with immediate access to all facilities, equipment, records, and personnel as required by the department to determine compliance with this subdivision; (iv) comply with all public health law and federal requirements for reporting reportable diseases and conditions to the same extent and in the same manner as a clinical laboratory; (v) perform one or more tests as required by the department to determine the proficiency of the persons performing such tests; and (vi) designate a qualified health care professional or qualified individual holding a certificate of qualification pursuant to section five hundred seventy-three of this title, who shall be jointly and severally responsible for: (A) establishing, approving and continuously updating policies, procedures and personnel qualifications for each test employed; (B) establishing a comprehensive quality assurance system which includes, but is not limited to, test selection, test quality, laboratory proficiency and personnel competency; (C) ensuring all tests are performed in accordance with the manufacturers' instructions and standards of practice in laboratory medicine; (D) maintaining complete and accurate records of the tests performed, including but not limited to, the patient's name, results, person performing the test, and quality control data; (E) ensuring that persons do not participate in diagnostic or treatment decisions using such test results unless such persons are authorized by law to do so; (F) ensuring that provider-performed microscopy procedures are performed only by a qualified health care professional operating within the scope of practice for his or her profession and as part of the physical examination performed by such professional; and (G) complying with other applicable laws, rules and regulations.

(d) A certificate of registration shall become void by a change in the owner of the laboratory test registrant or location of testing.

(e) Notwithstanding the foregoing, if the commissioner determines that

the performance of a particular waived test or provider-performed microscopy procedure in a facility or location which does not possess a New York state clinical laboratory permit creates a risk of harm to the subjects of such test, the commissioner may issue an order prohibiting such test from being performed in any location other than a permitted clinical laboratory, physician's office or other location exempted by subdivision one or two of this section.

(f) Registration under this subdivision may be denied, limited, suspended, revoked or annulled by the department upon a determination that a laboratory services registrant: (i) failed to comply with the requirements of this subdivision; (ii) provided services that constitute an unwarranted risk to human health; (iii) intentionally provided any false or misleading information to the department relating to registration or performing laboratory services; or (iv) has demonstrated incompetence or shown consistent errors in the performance of examinations or procedures. A registration shall not be limited, suspended, revoked or annulled without a hearing conducted in accordance with subdivision four of section five hundred seventy-seven of this title. However, a registration may be temporarily limited, suspended, revoked or annulled without a hearing for a period not to exceed thirty days upon notice to the registrant following a finding by the department that the public health, safety or welfare is in imminent danger.

(g) The commissioner may adopt such rules and regulations as may be necessary to effectuate the purposes of this subdivision.

(h) Any person, partnership, corporation or other entity performing waived tests or provider-performed microscopy procedures without being authorized to do so pursuant to this title shall be subject to a civil penalty of up to five hundred dollars for each test performed, not to exceed two thousand dollars per day for each day tests are performed, in violation of this subdivision.

(i) All fees and civil penalties collected pursuant to this subdivision shall be deposited in the special revenue account established for the receipt of inspection and reference fees collected pursuant to section five hundred seventy-six of this title and shall be subtracted from the operating expenses of the department prior to calculation of such inspection and reference fees.

§ 580. Construction. 1. Nothing in this title shall be construed as affecting the educational program of any college or university or any legally chartered school approved by the department of education which program is conducted for the training of its students.

2. Nothing in this title shall be construed as affecting facilities which perform laboratory tests solely for research purposes, nor as affecting laboratory testing by a public health officer as part of an epidemiological investigation in which no patient identified result is reported for diagnostic purposes to a health care provider or the subject of the test.

3. (a) Nothing in this title shall be construed to impair or affect the power or authority of the city of New York or a department or agency thereof, to enact or enforce additional laws, codes or regulations affecting clinical laboratories or blood banks, not inconsistent with the provisions of this title or any regulations promulgated hereunder, related to the control, prevention or reporting of diseases or medical conditions or to the control or abatement of public health nuisances. Noncompliance with such laws, codes or regulations as documented by the local public health officer may be a basis for the department's denial or non-renewal of a laboratory permit or a certificate of qualification.

(b) Such local laws, codes or regulations which are more restrictive than or additional to the requirements set forth in this title or the regulations promulgated hereunder shall be deemed not inconsistent.

4. The collection, processing, storage, distribution or use of blood, blood components or blood derivatives for the purpose of diagnosis, prevention or treatment of disease is hereby declared to be a public health service and shall not be construed to be, and is declared not to be, a sale of such blood, blood components or blood derivatives, for any purpose or purposes whatsoever.

5. Notwithstanding any inconsistent provision of the education law, individuals performing only waived tests or provider-performed microscopy procedures in accordance with the provisions of subdivision

three of section five hundred seventy-nine of this title shall not be required to be licensed or certified as a clinical laboratory practitioner pursuant to the education law.

§ 581. Separability. If any clause, sentence, paragraph, section or part of this title shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section, or part thereof directly involved in the controversy in which the judgment shall have been rendered.

TITLE VI

LABORATORY BUSINESS PRACTICES

Section 585. Definitions.

586. Payment for services.

587. Prohibited practices.

588. Violations and penalties.

§ 585. Definitions. Whenever used in this title:

1. "Health services purveyor" means any person, firm, partnership, group, association, corporation or professional corporation, or any agent, employee, fiduciary, employer or representative thereof, including but not limited to a physician, dentist, podiatrist or chiropractor, either in individual practice, group practice or employed in a facility owned by any person, group, association, firm, partnership or corporation hiring any of the aforementioned practitioners, who provide health or health related services.

2. "Clinical laboratory" shall have the same meaning as is set forth in subdivision one of section five hundred seventy-one of this article.

§ 586. Payment for services. 1. It shall be unlawful for any purveyor of clinical laboratory services, directly or indirectly, through any person, firm, corporation or association or its officers or agents, to bill or receive payment, reimbursement, compensation or fee from any person other than the recipient of the services, such recipient being the person upon whom the clinical services have been or will be rendered.

2. The provisions of subdivision one of this section shall be inapplicable to services rendered by a clinical laboratory operated by the state of New York; and to payment by:

- (a) A legal relative of the recipient of the services;
- (b) An insurance carrier designated by the recipient of the services;
- (c) A hospital as defined in article twenty-eight of this chapter on behalf of an in-patient or out-patient of such hospital having been the recipient of the services;
- (d) One purveyor to another purveyor for actual services rendered;
- (e) An industrial firm only for its own employees;
- (f) A trade union health facility only for its registered patients;
- (g) Governmental agencies and/or their specified public or private agent, agency or organization on behalf of the recipient of the services;
- (h) A substance abuse or chemical dependence program which has been approved to operate by the office of alcoholism and substance abuse services pursuant to the provision of section 23.01 or article thirty-two of the mental hygiene law on behalf of clients of such a program having been the recipient of the services; and
- (i) A health maintenance organization operating in accordance with article forty-three of the insurance law or article forty-four of this chapter.

3. The public health council shall adopt and amend rules and regulations, subject to approval by the commissioner, to effectuate the provisions and purposes of this section.

§ 587. Prohibited practices. 1. No health services purveyor shall

solicit, receive, accept or agree to receive or accept any payment or other consideration in any form to the extent such payment or other consideration is given for the referral of services or participate in the division, transference, assignment, rebate, splitting of fees, with any clinical laboratory or its agent, employee or fiduciary, or with another health services purveyor in relation to clinical laboratory services. Specifically prohibited practices shall include, without limiting thereto, the following:

(a) Acceptance of payments for rental of space for more than the fair market value or where the rental amount is affected by test ordering volume or value.

(b) Acceptance of rental payments for storage space for any supplies provided by any clinical laboratory or its agent, employee or fiduciary.

(c) Acceptance of payments for filling in proper information on laboratory request forms for tests.

(d) Receipt or acceptance of employees, agents or other fiduciaries of any clinical laboratory to perform any duties in the facility of any health services purveyor provided, however, that nothing in this subdivision shall prohibit a hospital as defined in article twenty-eight of this chapter or a health maintenance organization operating in accordance with article forty-three of the insurance law or article forty-four of this chapter and a clinical laboratory from contracting for laboratory management services including the provision of technical services and employees for the performance of functions directly related to clinical laboratory operations.

(e) Receipt or acceptance of equipment, supplies or services provided by any clinical laboratory or its agent, employee or fiduciary for less than fair market value or when the purchase price or rental payment is in any way related to the reference of patients or specimens to any clinical laboratory.

(f) Receipt or acceptance of any monies or other consideration from any clinical laboratory or its agent, employee or fiduciary as a bonus, commission or fee in the form of a fixed or percentage return for the number or dollar value of laboratory tests performed or to be performed by any clinical laboratory to which patients or specimens are referred or for the number of patients or specimens referred.

(g) The purchase of prepayment coupons, tickets, booklets or any

variation of such prepayment instruments as advance payments by purveyors of health services for clinical laboratory services to be rendered by any clinical laboratory.

(h) To accept payment of money or other consideration from anyone for any clinical laboratory tests rendered or to be rendered on any specimen for transference of the money or other consideration in whole or in part to any clinical laboratory or to actually be kept by the health services purveyor.

(i) To accept or use directly any instrument or any clinical laboratory form marked "Invoice", "Receipt", "Payment Received" or any other variation for issuance to patients as if the patient had been billed and paid the clinical laboratory.

(j) Receipt or acceptance of any monies or other consideration from any clinical laboratory or its agent, employee or fiduciary for influencing any person to refrain from using or utilizing any other clinical laboratory.

2. No clinical laboratory or its agent, employee or fiduciary shall make, offer, give, or agree to make, offer, or give any payment or other consideration in any form to the extent such payment or other consideration is given for the referral of services or participate in the division, transference, assignment, rebate, splitting of fees, with any health services purveyor, or with another clinical laboratory. Specifically prohibited practices shall include, without limiting thereto, the following:

(a) To offer or agree to give or give any payments for rental of space for more than the fair market value or where the rental amount is affected by test ordering volume or value.

(b) To offer or agree to give or give rental payments for storage space for any supplies provided to any health services purveyor.

(c) To offer or agree to give or give any payments for filling in proper information on laboratory request forms for tests.

(d) To supply employees, agents or other fiduciaries of any clinical laboratory to perform any duties in the facility of any health services purveyor provided, however, that nothing in this subdivision shall prohibit a hospital as defined in article twenty-eight of this chapter or a health maintenance organization operating in accordance with

article forty-three of the insurance law or article forty-four of this chapter and a clinical laboratory from contracting for laboratory management services, including the provision of technical services and employees for the performance of functions directly related to clinical laboratory operations.

(e) To offer or agree to give or give any equipment, supplies or services to any health services purveyor for less than fair market value or when the purchase price or rental payment is in any way related to the reference of patients or specimens to any clinical laboratory.

(f) To offer or agree to give or give any monies or other consideration to any health services purveyor as a bonus, commission or fee in the form of a fixed or percentage return for the number or dollar value of laboratory tests performed or to be performed by any clinical laboratory to which patients or specimens are referred or for the number of patients or specimens referred.

(g) To sell any prepayment coupons, tickets, booklets or any variation of such prepayment instrument as advance payments by purveyors of health services for clinical laboratory services.

(h) To send a bill to or receive payment from any health services purveyor for clinical laboratory services rendered to any patient, where such bill is sent in code on blank paper, without name and address of the clinical laboratory, without name or address of the addressee, or without name or other identifying information of the person who was the recipient of the laboratory service or in any other falsified manner.

(i) To utilize any health services purveyor or anyone else not authorized by law to collect money or other consideration from anyone for any clinical laboratory tests rendered or to be rendered on any specimen for transference of the money or other consideration in whole or in part to the clinical laboratory or to be actually kept by the health services purveyor.

(j) To supply to any health services purveyor any printed form of a clinical laboratory marked "Invoice", "Receipt", "Payment Received", or any other variation for use by any health services purveyor issuing same to patients as if the patient had paid the clinical laboratory.

(k) To offer or agree to give or give any monies or other consideration for influencing any person to refrain from using or utilizing any other clinical laboratory.

3. This section shall not apply to any: (a) legally established hospital group purchasing program approved by the commissioner, or (b) any arrangement between a clinical laboratory and health maintenance organization operating in accordance with article forty-three of the insurance law or article forty-four of this chapter approved by the commissioner.

4. Any transaction excluded from the prohibition of section five hundred eighty-six of this title relating to payment for services rendered by clinical laboratories shall be deemed to be similarly excluded from the application of this section.

5. No clinical laboratory or its agent, employee or fiduciary shall make, offer, give or agree to make, offer or give to any person, partnership, corporation or other entity any payment or other consideration in any form as a bonus, commission or fee for securing referrals of services to the clinical laboratory except for payments made to a person who is an employee of the clinical laboratory.

6. The public health council shall adopt and amend rules and regulations, subject to approval by the commissioner, to effectuate the provisions and purposes of this section.

§ 588. Violations and penalties. 1. Any health services purveyor, clinical laboratory, or any agent, employee or fiduciary of a health services purveyor or clinical laboratory who violates the provisions of section five hundred eighty-six of this title, or any rule or regulation adopted pursuant thereto, is guilty of a class A misdemeanor and shall be punishable in accordance with the provisions of the penal law.

2. Any health services purveyor, clinical laboratory, or any agent, employee or fiduciary of a health services purveyor or clinical laboratory who violates the provisions of section five hundred eighty-seven of this title, or any rule or regulation adopted pursuant thereto, is guilty of a misdemeanor and shall be punishable by:

- (a) a term of imprisonment in accordance with the penal law; or
- (b) a fine of not less than five hundred dollars nor more than ten thousand dollars; or
- (c) if the defendant has gained money or property through a violation of the provisions of this section, a fine in an amount, fixed by the court, not to exceed double the amount of the defendant's gain from a violation of such provisions. In such event, the provisions of subdivision three of section 80.00 of the penal law shall be applicable to the sentence; or
- (d) both the imprisonment and the fine.

ARTICLE 6

STATE AID TO CITIES AND COUNTIES

- Title
- I. State aid for basic services. (§§ 600-607)
 - II. State aid for additional services. (§§ 608-613)
 - III. State aid; general provisions. (§§ 614-621)

TITLE I

STATE AID FOR BASIC SERVICES

- Section 600. State aid; general requirements.
- 601. Application for state aid.
 - 602. Core public health services.
 - 602-a. Community health assessment.
 - 603. Core public health services; implementation.
 - 604. Supervision of public health programs.
 - 605. State aid; amount of reimbursement.
 - 606. Assessment of fees; third-party coverage or indemnification.
 - 607. Supplemental health services grants.

§ 600. State aid; general requirements. In order to be eligible for state aid under this title, a municipality shall be required to do the following in accordance with the provisions of this article:

1. submit an application to the department for state aid which is approved by the commissioner in accordance with section six hundred one of this title;

2. provide core public health services, as defined in section six hundred two of this title, in accordance with an application for state aid submitted by the municipality and approved by the commissioner;

3. submit a community health assessment in accordance with section six hundred two-a of this title;

4. establish, collect and report fees and revenue for services provided by the municipality, in accordance with section six hundred six of this title; and

5. appropriate or otherwise make funds available to finance a prescribed share of the cost of public health services.

§ 601. Application for state aid. 1. The governing body of each municipality desiring to make application for state aid under this title shall annually, on such dates as may be fixed by the commissioner, submit an application for such aid.

2. The application shall be in such form as the commissioner shall prescribe, and shall include, but not be limited to:

(a) an organizational chart of the municipal health agency, and a statement providing the number of employees, by job title, proposed to provide public health services funded by this title;

(b) a budget of proposed expenditures for services funded by this title;

(c) a description of how the municipality will provide public health services;

(d) an attestation by the chief executive officer of the municipality that sufficient funds have been appropriated to provide the public health services for which the municipality is seeking state aid;

(e) an attestation by the municipal officer in charge of administering

public health that the municipality has diligently reviewed its state aid application and that the application seeks state aid only for eligible public health services;

(f) a list of public health services provided by the municipality that are not eligible for state aid, and the cost of each service;

(g) a projection of fees and revenue to be collected for public health services eligible for state aid, in accordance with section six hundred six of this title; and

(h) such other information as the commissioner may require.

3. The commissioner shall approve the state aid application to the extent that it is consistent with this section and any other conditions or limitations established in, or regulations promulgated pursuant to, this article.

4. A municipality may amend its state aid application with the approval of the commissioner, and subject to any rules and regulations that the commissioner may adopt.

§ 602. Core public health services. 1. To be eligible for state aid, a municipality must provide the following core public health services:

(a) Family health, which shall include activities designed to reduce perinatal, infant and maternal mortality and morbidity and to promote the health of infants, children, adolescents, and people of childbearing age. Such activities shall include family centered perinatal services and other services appropriate to promote the birth of a healthy baby to a healthy mother, and services to assure that infants, young children, and school age children are enrolled in appropriate health insurance programs and other health benefit programs for which they are eligible, and that the parents or guardians of such children are provided with information concerning health care providers in their area that are willing and able to provide health services to such children. Provision of primary and preventive clinical health care services shall be eligible for state aid for uninsured persons under the age of twenty-one, provided that the municipality makes good faith efforts to assist such persons with insurance enrollment and only until such time

as enrollment becomes effective. Provision of prenatal clinical health care services shall be eligible for state aid for uninsured women of any age, provided that the municipality makes good faith efforts to assist such women with insurance enrollment and only until such time as enrollment becomes effective.

(b) Communicable disease control, which shall include activities to control and mitigate the extent of infectious diseases. Such activities shall include, but not be limited to, surveillance and epidemiological programs, programs to detect diseases in their early stages, immunizations against infectious diseases, investigation of diseases and prevention of transmission, prevention and treatment of sexually transmissible diseases, and arthropod vector-borne disease prevention.

(c) Chronic disease prevention, which shall include promoting public, health care provider and other community service provider activities that encourage chronic disease prevention, early detection and quality care delivery. Such activities include, but are not limited to, those that promote healthy communities and reduce risk factors such as tobacco use, poor nutrition and physical inactivity. Provision of clinical services shall not be eligible for state aid, subject to such exceptions as the commissioner may deem appropriate.

(d) Community health assessment, as described in section six hundred two-a of this article.

(e) Environmental health, which shall include activities that promote health and prevent illness and injury by assuring that safe and sanitary conditions are maintained at public drinking water supplies, food service establishments, and other regulated facilities; investigating public health nuisances to assure abatement by responsible parties; protecting the public from unnecessary exposure to radiation, chemicals, and other harmful contaminants; and conducting investigations of incidents that result in illness, injury or death in order to identify and mitigate the environmental causes to prevent additional morbidity and mortality.

(f) Public health emergency preparedness and response, including planning, training, and maintaining readiness for public health emergencies.

2. The municipality must incorporate into each core public health

service the following general activities:

- (a) ongoing assessment of community health needs;
- (b) education on public health issues;
- (c) development of policies and plans to address health needs; and
- (d) actions to assure that services necessary to achieve agreed upon goals are provided.

3. The commissioner may approve a state aid application in which the municipality actually provides fewer services than those set forth in subdivision one of this section as long as the application identifies the availability of other services, who will provide those services and the manner in which the services will be provided and financed.

4. The commissioner shall consult with the county health commissioners, public health directors, and boards of public health when promulgating rules and regulations to effectuate the provisions and purposes of this article. The commissioner shall not have the power to prescribe the number of persons to be employed by any municipality.

§ 602-a. Community health assessment. 1. Every municipality shall submit to the department no more frequently than every two years, a community health assessment.

2. The community health assessment shall be in such form as the commissioner shall prescribe, and shall include, but not be limited to:

- (a) an estimate and description of the health status of the population and factors that contribute to health issues;
- (b) identification of priority areas for health improvement, in conjunction with the state health improvement plan;
- (c) identification of public health services in the municipality and in the community and other resources that can be mobilized to improve population health, particularly in those priority areas identified in paragraph (b) of this subdivision; and
- (d) a community health improvement plan consisting of actions, policies, strategies and measurable objectives through which the municipality and its community partners will address areas for health

improvement and track progress toward improvement of public health outcomes.

§ 603. Core public health services; implementation. 1. In order to be eligible for state aid under this title, each municipality shall administer its core public health services in accordance with the standards of performance established by the commissioner through rules and regulations pursuant to section six hundred nineteen of this article. Each municipality shall, in particular, ensure that public health services are provided in an efficient and effective manner to all persons in the municipality.

2. The commissioner may withhold state aid reimbursement under this title for the appropriate services if, on any audit, review of a state aid application or periodic claim for state aid, or other information available to the department, the commissioner finds that such services are not furnished or rendered in conformance with the rules and regulations established by the commissioner, including but not limited to the standards of performance established pursuant to section six hundred nineteen of this article, or that the expenditures were not for an activity set forth in section six hundred two of this title. In such cases, the commissioner, in order to ensure that the public health is promoted as defined in section six hundred two of this title, may use any proportionate share of a municipality's per capita or base grant that is withheld to contract with agencies, associations, or organizations. The health department may use any such withheld share to provide services upon approval of the director of the division of the budget. Copies of such transactions shall be filed with the fiscal committees of the legislature.

3. Consistent with paragraph (h) of subdivision two of section six hundred one of this title, when determining whether to approve a state aid application or periodic claim for state aid, the commissioner shall have authority to request any and all financial and other documents necessary or relevant to verify that the claimed expenditures are eligible for state aid under this article.

§ 604. Supervision of public health programs. In order to be eligible for state aid, under this title, each municipality shall employ a full-time local commissioner of health or public health director to supervise the provision of public health services for that municipality, subject to the following exceptions:

1. such person may serve as the head of a merged agency or multiple agencies, if the approval of the commissioner is obtained; and
2. such person may serve as the local commissioner of health or public health director of additional counties, when authorized pursuant to section three hundred fifty-one of this chapter.

§ 605. State aid; amount of reimbursement. 1. A state aid base grant shall be reimbursed to municipalities for the core public health services identified in section six hundred two of this title, in an amount of the greater of one dollar and thirty cents per capita, for each person in the municipality, or seven hundred fifty thousand dollars, provided that the municipality expends at least seven hundred fifty thousand dollars, for such core public health services. A municipality must provide all the core public health services identified in section six hundred two of this title to qualify for such base grant unless the municipality has the approval of the commissioner to expend the base grant on a portion of such core public health services. If any services in such section are not provided, the commissioner shall limit the municipality's per capita or base grant to reflect the scope of the reduced services, in an amount not to exceed five hundred seventy-seven thousand five hundred dollars. The commissioner may use the amount that is not granted to contract with agencies, associations, or organizations to provide such services; or the health department may use such proportionate share to provide the services upon approval of the director of the division of the budget.

2. State aid reimbursement for public health services provided by a

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

3. Municipalities shall make every reasonable effort to collect payments for public health services provided. All such revenues shall be reported to the commissioner pursuant to section six hundred six of this title and will be deducted from expenditures identified under subdivision two of this section to produce a net cost eligible for state aid.

§ 606. Assessment of fees; third-party coverage or indemnification. 1. Assessment of fees by municipalities. Each municipality shall establish a schedule of fees for public health services provided by the municipality and shall make every reasonable effort to collect such fees. Fees for personal health services shall be reflective of an individual's ability to pay and shall not be inconsistent with the reimbursement guidelines of articles twenty-eight and thirty-six of this chapter and applicable federal laws and regulations. To the extent possible revenues generated shall be used to enhance or expand public health services. In its state aid application, each municipality shall provide the department with a projection of fees and revenue to be collected for that year. Each municipality shall periodically report to the department fees and revenue actually collected.

2. Assessment of fees by the commissioner. In each municipality, the

commissioner shall establish a fee and revenue plan for services provided by the department in a manner consistent with the standards and regulations established pursuant to subdivision one of this section.

3. Third party coverage or indemnification. For any public health service for which coverage or indemnification from a third party is available, the municipality must seek such coverage or indemnification and report any associated revenue to the department in its state aid application.

§ 607. Supplemental health services grants. 1. There shall be established within the special revenue fund-other a local public health services program account. All revenues derived from fees collected by the department pursuant to subdivision two of section six hundred six of this article and all fines levied and collected by the department from enforcement actions pursuant to the services provided under titles one and two of this article, and monies received or recovered as a result of any audit exception assessed against the state aid reimbursement to a municipality under this article, shall be deposited in the local public health services program account.

2. Notwithstanding the limitations of available state aid defined in section six hundred sixteen of this article, monies available for supplemental health services grants in the local health services program account shall be used by the commissioner for the purpose of providing supplemental health services grants to municipalities for the enhancement of public health services, as an incentive for a municipality not organized as a county health district or a part-county health district to become organized or in recognition of municipalities which have consistently maximized revenue collections. Criteria for eligibility for grants under this section shall be established by the commissioner. Monies received from such supplemental grants shall be used to enhance or expand public health services and may not supplant the amount that otherwise would be provided by the municipality or appropriated to the department.

TITLE II

STATE AID FOR ADDITIONAL SERVICES

Section 608. State aid; children and youth with special health care needs support services.

609. State aid; laboratories.

613. State aid; immunization.

§ 608. State aid; children and youth with special health care needs support services. 1. Whenever the commissioner of health of any county or part-county health district or, in a county lacking a county or part-county health district, the medical director of the children and youth with special health care needs support services program, or the department of health of the city of New York, issues an authorization for medical service for a child with physical disabilities, such county or the city of New York shall be granted state aid in an amount of fifty per centum of the amount expended in accordance with the rules and regulations established by the commissioner, except that such state aid reimbursement may be withheld if, on post-audit and review, the commissioner finds that the medical service rendered and furnished was not in conformance with a plan submitted by the municipality and with the rules and regulations established by the commissioner or that the recipient of the medical service was not a child with a physical disability as defined in section two thousand five hundred eighty-one of this chapter.

2. Whenever a court of any county issues an order for medical services for any Indian child with a physical disability, residing on an Indian reservation, such county shall be granted state aid in the amount of one hundred percent of the amount expended in accordance with the standards established by the commissioner. Such reimbursement shall be made from any funds appropriated to the department for payment of state aid for children with physical disabilities.

3. The clerk of the board of supervisors or other similar governing body of each county, or chief fiscal officer of the city of New York

which has paid claims as provided herein shall, not oftener than once in each month, transmit to the commissioner a certified statement in the form prescribed by him, stating the amount expended for the purposes specified herein, the date of each expenditure, and the purpose for which it was made. Upon the receipt of such certified statement the commissioner shall examine the same, and if such expenditures were made as required by law he shall approve it and transmit it to the comptroller for audit. The comptroller shall thereupon issue his warrant in the amount specified in such approved statement for the payment thereof out of moneys appropriated therefor to the county treasurer of the county or chief fiscal officer of the city of New York.

§ 609. State aid; laboratories. 1. Where a laboratory shall have been or is hereafter established pursuant to article five of this chapter, the state, through the legislature and within the limits to be prescribed by the commissioner, shall provide aid at a per centum, determined in accordance with the provisions of subdivision two of section six hundred five of this article, of the actual cost of repair, relocation, equipment and maintenance of the laboratory or laboratories for services associated with a core public health service, as described in section six hundred two of this title. Such cost shall be the excess, if any, of such expenditures over available revenues of all types, including adequate and reasonable fees, derived from or attributable to the performance of laboratory services.

2. Where a county or city provides or shall have provided for laboratory service by contracting with an established laboratory for services associated with a core public health service, as described in subdivision three of section six hundred two of this title, with the approval of the commissioner, it shall be entitled to state aid at a per centum, determined in accordance with the provisions of subdivision two of section six hundred five of this article, of the cost of the contracts.

3. The work of all laboratories except the laboratories in the department of health in the city of New York established or for which

aid is received in accordance with the provisions of this chapter shall be inspected and standardized by the commissioner and no state aid shall be given to any county or city unless the area of the district, site, design and construction of the buildings, equipment, work and conduct of the laboratory shall be first approved in writing, after inspection, by the commissioner or his representative.

4. The governing body of any county or city which has established and is maintaining a laboratory or which is providing laboratory services by contract with another laboratory and which desires to make applications for state aid under this title shall annually on such dates as may be fixed by the commissioner submit the request of such county or city for such state aid and shall support such request with such information as the commissioner may require. The commissioner shall prescribe the form in which such information shall be submitted.

§ 613. State aid; immunization. 1. (a) The commissioner shall develop and supervise the execution of a program of immunization, surveillance and testing, to raise to the highest reasonable level the immunity of the children of the state against communicable diseases including, but not limited to, influenza, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type b (Hib), diphtheria, pertussis, tetanus, varicella, hepatitis B, pneumococcal disease, and the immunity of adults of the state against diseases identified by the commissioner, including but not limited to influenza, smallpox, hepatitis and such other diseases as the commissioner may designate through regulation. Municipalities in the state shall maintain local programs of immunization to raise the immunity of the children and adults of each municipality to the highest reasonable level, in accordance with an application for state aid submitted by the municipality and approved by the commissioner. Such programs shall include assurance of provision of vaccine, serological testing of individuals and educational efforts to inform health care providers and target populations or their parents, if they are minors, of the facts relative to these diseases and immunizations to prevent their occurrence.

(b) In connection with efforts to raise the immunity of children

against influenza, the commissioner shall administer a program of influenza education to the families of children ages six months to eighteen years of age who attend licensed and registered day care programs, nursery schools, pre-kindergarten, kindergarten, school age child care programs, public schools or non-public schools. Such program shall include educational materials on influenza and the benefits of influenza immunizations to be made available on the department's website in anticipation of times of highest risk for contraction of influenza as determined by the commissioner. The office of children and family services, the department of education, and the New York city department of health and mental hygiene shall, as part of their routine notification processes, notify licensed and registered day care programs, nursery schools, pre-kindergarten programs, kindergarten programs, school age child care programs, public schools and non-public schools that the information regarding immunizations for influenza is free and accessible on the department's website and such information shall be posted in such licensed and registered day care programs, nursery schools, pre-kindergartens, kindergartens, school age child care programs, public schools and non-public schools in plain view in anticipation of such times of highest risk for contraction of influenza as determined by the commissioner.

(c) The commissioner shall invite and encourage the active assistance and cooperation in such education activities of: the medical societies, organizations of other licensed health personnel, hospitals, corporations subject to article forty-three of the insurance law, trade unions, trade associations, parents and teachers and their associations, organizations of child care resource and referral agencies, the media of mass communication, and such other voluntary groups and organizations of citizens as he or she shall deem appropriate. The public health and health planning council, the department of education, the department of family assistance, and the department of mental hygiene shall provide the commissioner with such assistance in carrying out the program as he or she shall request. All other state agencies shall also render such assistance as the commissioner may reasonably require for this program. Nothing in this subdivision shall authorize mandatory immunization of adults or children, except as provided in sections twenty-one hundred sixty-four and twenty-one hundred sixty-five of this chapter.

2. The commissioner shall set such standards as he shall deem necessary for the proper, safe, and efficient administration of the program. He shall direct an annual survey to determine the immunization level of children entering school, and shall conduct annually an audit of such survey and an audit of the immunization level of children attending school. State aid provided by this article shall be reduced by ten percent, provided however that state aid for essential public health activities shall not be reduced, unless a municipality has submitted, in cooperation with local school districts, a plan within ninety days after the commissioner shall have certified to such municipality the results of his survey of the immunization level of children entering schools in such local school districts. Such plan shall be submitted for the next ensuing school year and a subsequent plan shall be submitted annually thereafter for assuring that immunizing agents are administered to pre-school children within a reasonable time prior to but, in any event, no later than their entrance into school, and to students generally, as required pursuant to section twenty-one hundred sixty-four of this chapter. Such plan shall include the manner in which immunization activities are coordinated among the local health authority and the school districts. Such reduction in state aid and the requirement that a municipality submit an immunization plan shall not be applicable to any municipality where ninety percent or more of its children entering school are immunized. The determination of the percentage of immunization shall be made by the commissioner based upon his audit of immunization surveys.

3. The commissioner shall expend such funds as the legislature shall make available for the purpose of adult and child immunization programs, including quality assurance and immunization education:

- (a) directly through the department;
- (b) by allocation to municipalities with qualifying programs for reimbursement in accordance with provisions of this section; or
- (c) by contract.

4. The commissioner shall expend such funds as the legislature shall make available for the purchase of the vaccines described in subdivision

one of this section. Vaccines purchased with funds made available under this section shall be made available without charge to licensed private physicians, hospitals, clinics and such others as the commissioner shall determine, and no charge shall be made to any patient for such vaccines.

TITLE III

STATE AID; GENERAL PROVISIONS

- Section 614. Definitions.
- 615. State aid; form.
 - 616. Limitations on state aid.
 - 617. Maintenance of effort.
 - 618. Performance and accountability.
 - 619. Commissioner; regulatory powers.
 - 619-a. Incentive standards of performance.
 - 620. Public health services program audit recoveries.
 - 621. State aid; public health emergencies.

§ 614. Definitions. The following terms shall have the following meanings:

1. "County", any county of the state other than one wholly embraced within a city or any combinations of counties or parts of a county that constitutes a health district.

2. "City", each city of the state having a population of one million or more, according to the last preceding federal census.

3. "Municipality", a county or city.

4. "Governing body", the board of supervisors of a county or the common council, city council or other legislative body of a city or county.

5. "Local commissioner of health", the officer who administers and manages public health programs within a county who is appointed pursuant

to section three hundred fifty-one of this chapter and who has the general powers and duties specified in section three hundred fifty-two of this chapter and the commissioner of health in a city having a population of more than one million.

6. "Public health director", a person, including a county health director, who, with appropriate medical consultation, administers and manages public health programs within a county, or a city having a population of less than two hundred fifty thousand, and who meets the qualifications as prescribed pursuant to section two hundred twenty-five of this chapter.

§ 615. State aid; form. The appropriations made or to be made for the purposes of carrying out the provisions of this article shall be available, in accordance with certificates of approval issued or to be issued by the director of the budget, to the commissioner for the payment of state aid to municipalities.

§ 616. Limitations on state aid. 1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by subdivision two of section six hundred five of this article, no less than thirty-six per centum of the difference between the amount of moneys expended by the municipality for eligible public health services pursuant to an approved application for state aid during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article.

2. No payments shall be made from moneys appropriated for the purpose of this article to a municipality for contributions by the municipality for indirect costs.

3. Administrative policy changes relating to state aid shall not be implemented without reasonable and statewide advance written notice to

municipalities.

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

§ 617. Maintenance of effort. Such amount of state aid provided will be used to support and to the extent practicable, to increase the level of funds that would otherwise be made available for such purposes and not to supplant the amount to be provided by the municipalities. If a municipality that is provided state aid pursuant to title one of this article reduces its expenditures beneath the amount expended in its base year, which is the most recent fiscal year for which the municipality has filed all expenditure reports to the department, state aid reimbursement provided pursuant to subdivision one of section six hundred five of this article will be reduced by the percentage reduction in expenditures between its base year and its current fiscal year. For purposes of this section, reductions in expenditures shall be adjusted for: an absence of extraordinary expenditures of a temporary nature, such as disaster relief; unavoidable or justifiable program reductions, such as a program being subsumed by another agency; or in circumstances where the municipality can demonstrate, to the department's satisfaction, that the need for the expenditure no longer exists.

§ 618. Performance and accountability. The commissioner shall establish, in consultation with the municipalities, uniform statewide performance standards for the services funded pursuant to this article; provided, however, the commissioner may modify a specific standard for a municipality if such municipality demonstrates adequate justification. The commissioner shall recognize the particular needs and capabilities of the various municipalities. The commissioner shall monitor the

performance and expenditures of each municipality to ensure that each one satisfies the performance standards. Any municipality failing to satisfy its standards may be subject to a reduction or loss of aid until such municipality can demonstrate that it has the capacity to satisfy such standards. The commissioner shall establish a uniform accounting system for monitoring the expenditures for services of each municipality to which aid is granted and the amount of state aid received including any performance payments pursuant to section six hundred nineteen-a of this article. Such reporting system shall require information on the amount of public health moneys received from the federal government, the private sector, grants, and fees. Each such municipality shall comply with the regulations of such accounting and reporting systems.

§ 619. Commissioner; regulatory powers. The commissioner shall adopt regulations to effectuate the provisions and purposes of this article, including, but not limited to:

1. setting standards of performance for the provision of core public health services which shall include performance criteria to ensure that reimbursable health services are delivered in an efficient and effective manner by a municipality; and

2. monitoring, collecting data and evaluating the provision of core public health services by the municipalities and the amounts expended by the municipalities for such services.

§ 619-a. Incentive standards of performance. 1. The commissioner may establish statewide incentive performance standards for the delivery of core public health services.

2. Within amounts appropriated, and subject to the approval of the director of the budget, the commissioner may increase state aid to any municipality that meets or exceeds statewide incentive performance standards established under this section, provided that the total of such payments to all municipalities may not exceed one million dollars

annually.

§ 620. Public health services program audit recoveries. All monies received or recovered by the department after the effective date of this section as a result of any audit exception assessed against the state aid reimbursement to a municipality under this article shall be deposited in the local public health services program account.

§ 621. State aid; public health emergencies. If the state commissioner or a county health department or part-county department of health or municipality, with the approval of the state commissioner, determines that there is an imminent threat to public health, the department shall reimburse counties or municipalities at fifty per centum for the cost of emergency measures as approved by the department and subject to the approval of the director of the budget, except that aerial spraying for mosquitoes on state land shall be reimbursed at one hundred per centum, within amounts appropriated. Such funds shall be made available from funds appropriated for public health emergencies, only to those counties or municipalities, which have expended all other state aid which may be available for related activities and have developed measures to adequately address the emergency. Reimbursement is conditioned upon availability of appropriated funds. For purposes of this section, "municipality" means a health department of a city that is not located in a county or part-county health district or a county in which the legislature has the powers and duties of a board of health of a county or part-county health district and cities with a population of over one million persons.

ARTICLE 6-A

RAPE CRISIS INTERVENTION AND PREVENTION PROGRAM

Section 695. Short title.

695-a. Definitions.

695-b. Authorization of programs.

695-c. Technical assistance.

695-e. Assistance of other agencies.

§ 695. Short title. This article shall be known and may be cited as the "rape crisis intervention and prevention act of two thousand".

§ 695-a. Definitions. As used in this article:

1. "Rape crisis intervention and prevention program" means any program which has been approved by the department offering counseling and assistance to clients concerning sex offenses, sexual abuse, or incest.

2. "Community support system" means a system of service providers in a community designed to meet the needs of a victim of a sex offense, sexual abuse or incest.

3. "Comprehensive services" means hotline, counseling, community prevention, recruitment and training programs, accompaniment services, and referral.

4. "Counseling" means individual communication and interaction which helps the client make choices and act upon those choices, provided to a client concerning any sex offense, sexual abuse, incest, or attempt to commit a sex offense, sexual abuse, or incest.

5. "Client" means any person seeking or receiving the services of a rape crisis counselor for the purpose of securing counseling or assistance concerning any sex offense, sexual abuse, incest, or attempt to commit a sex offense, sexual abuse, or incest.

6. "Hotline" means twenty-four-hour access to rape crisis intervention and prevention services including telephone hotline and telephone counseling capabilities.

7. "Community prevention" means public education projects designed to encourage victim use of rape crisis intervention services, educating the

general public about the availability and significance of rape crisis intervention services, providing sex offense, sexual abuse or incest prevention and personal safety information, providing other education programs which sensitize service providers and the general public about the nature of sex offenses, sexual abuse or incest and the needs of survivors of a sex offense, sexual abuse or incest. "Community prevention" also means and includes public education projects designed to teach the general public about the problem of acquaintance rape, including but not limited to: (a) the importance of promptly respecting the decision of another person not to engage in sexual conduct; and (b) the right of every individual to make such a decision and have it respected.

8. "Recruitment and training programs" means programs designed to recruit and train staff or volunteers in a rape crisis intervention and prevention program as well as training or education to other agencies participating in a community support system.

9. "Accompaniment services" means services that assure the presence of a trained rape crisis worker to assist and support the client, at hospitals, law enforcement agencies, district attorneys' offices, courts and other agencies.

10. "Referral" means referral to and assistance with medical services and services of criminal justice agencies, mental health agencies, or other entities providing related services.

§ 695-b. Authorization of programs. 1. The department is hereby authorized to contract, within amounts appropriated, for the provision of rape crisis intervention and prevention programs as provided herein. Rules, regulations and guidelines as shall be necessary or appropriate to assure successful implementation of this program shall be promulgated by the department.

2. Nothing contained in this section shall prohibit a program, with the approval of the department, from subcontracting for, or otherwise

ensuring that the required services are available.

§ 695-c. Technical assistance. The department shall provide or arrange to provide technical assistance as requested and necessary to programs to develop appropriate services and train staff, improve coordination with other appropriate support services, the criminal justice system and other appropriate officials and services.

§ 695-e. Assistance of other agencies. To effectuate the purposes of this article, the department may request from any department, board, bureau, commission or other agency of the state, and the same are authorized to provide, such assistance, services and data as will enable the department to assure that the provisions and intent of this article are carried out.

ARTICLE 7

FEDERAL GRANTS-IN-AID

Section 700. Federal aid; department to administer.

701. Federal aid; powers and duties of commissioner.

702. Federal aid; custody and payment of funds.

703. Federal aid; allotments to municipalities and local health districts.

§ 700. Federal aid; department to administer. 1. The department is hereby designated as the agency of the state to administer the provisions of the federal social security act or any other act of the congress which relate to maternal and child health services, the care and treatment of children with physical disabilities and other public health work and to co-operate with the duly constituted federal authorities charged with the administration thereof.

2. The commissioner is authorized and empowered to take such steps, not inconsistent with law, as may be necessary for the purpose of

procuring for the people of this state all of the benefits and assistance, financial and otherwise, provided, or to be provided for, by or pursuant to any act of congress relating to maternal and child health services, care and treatment of children with physical disabilities and other public health work.

§ 701. Federal aid; powers and duties of commissioner. The commissioner is authorized and empowered:

(a) to receive and disburse pursuant to this article the federal-aid moneys allotted to the state by or pursuant to the federal social security act or any other act of the congress making appropriations for allocation among the states for maternal and child health services, care and treatment of children with physical disabilities and other state and local public health work;

(b) on behalf of the state, to adopt, execute and administer plans and to put into effect such measures as may be necessary for maternal and child health service, for the care and treatment of children with physical disabilities, and for other public health work in the state;

(c) on behalf of the state, to make and execute such contracts, agreements, covenants or conditions, not inconsistent with law, as may be necessary or required by any duly constituted agency of the federal government as a condition precedent to receiving or in connection with such benefits and assistance;

(d) to co-operate with all state or local authorities and agencies authorized under such acts of the congress to carry out the purposes thereof;

(e) to adopt and from time to time to amend such rules and regulations and to prescribe such conditions, not inconsistent with law, as may be necessary to make available to the people of the state the relief and assistance afforded by such act of the congress;

(f) to enforce all of the provisions of this article and rules adopted pursuant hereto.

§ 702. Federal aid; custody and payment of funds. 1. The department of taxation and finance is designated as custodian of all federal-aid funds

allotted to the state for the purposes of this article by the United States.

2. Such funds shall be payable only on the audit and warrant of the comptroller on the certificate of the commissioner as provided in section one hundred ten of the state finance law.

3. Subject to the rules and regulations of the commissioner, such funds may be allocated to any municipal corporation, including the city of New York, and to any health district for the use of such municipal corporation or local health district in carrying out the purposes of such act of the congress.

§ 703. Federal aid; allotments to municipalities and local health districts. 1. Notwithstanding the provisions of any general, special or local law, the governing body of any municipal corporation or of any health district by a majority vote may authorize the proper officials of such municipal corporation or local health district to accept grants or allotments made to such municipal corporation or health district by the commissioner for the purpose of extending or improving within such municipal corporation or local health district the maternal and child health services, the care and treatment of children with physical disabilities, and other public health work.

2. The commissioner is authorized and empowered to prescribe the terms and conditions, not inconsistent with law, which must be fulfilled, and the standards of service which must be met by the authorities of any municipal corporation or health district in order to receive such allotment of federal-aid moneys.

ARTICLE 8

STATE HEALTH RESEARCH COUNCIL

Section 800. State health research council.

801. Organization; executive director.

802. Powers and duties.

803. Gender-specific questions on grant applications.

§ 800. State health research council. There is hereby established in the health department a state health research council. The council shall consist of the commissioners of health, mental hygiene, environmental conservation, and education, the chancellor of the state university and such other persons as the governor shall appoint, not exceeding twenty-nine in number inclusive of the ex-officio members. The chairman of the council shall be appointed by the governor. All appointments to the council shall be upon the advice and consent of the senate. Members shall serve for three-year terms; provided, however, that of the members first appointed pursuant to this section, ten shall serve for a term of one year only, and ten shall serve for a term of two years only. Members of the council shall receive no compensation for their services as members, but shall be allowed their actual and necessary expenses incurred in the performance of their duties. The principal office of the council shall be located in the county of Albany.

§ 801. Organization; executive director. The council may organize into such organizational units as the members determine to be necessary. The chairman shall appoint an executive director for the council. The department and any institute created by this chapter are authorized to supply such staff and services to the council as may be necessary for the council to fulfill its functions under this article.

§ 802. Powers and duties. 1. The council shall have the power and duty to:

- a. identify strategic areas for health research;
- b. conduct ongoing surveys of the state allocation of health research sources;
- c. develop health research programs and establish priorities for such

programs;

d. assure that women's health needs as well as men's have been considered in research programs which the council develops and in the priorities it establishes;

e. review and disseminate the results of health research programs;

f. stimulate independent health research;

g. coordinate health research within New York state to avoid unnecessary duplication of effort and facilities;

h. encourage health research in designated priority areas by assisting research projects in obtaining grants or fellowships;

i. develop a model health research plan for the state;

j. hold meetings at least semiannually. Special meetings may be called by the chairman;

k. encourage education and training in the area of health research;

l. accept on behalf of the state any grant, gift, devise or bequest, made to the health research council; and to cause the department of taxation and finance to establish from all such monies a special trust fund to be used under the direction of the council for the purpose of health research and training. Such grants, gifts, devises or bequests shall be accepted subject to the provisions of section fifty-three-a of the state finance law and subject to audit by the state comptroller;

m. make rules and regulations for the exercise of the council's powers and performance of its duties in order to carry out the provisions of this article; and

n. exercise and perform such other functions, powers, and duties as may from time to time be conferred or imposed by law.

2. For the purposes of this section research shall not include the actual delivery of health care or equipment for health care provided by existing institutes established by this chapter to conduct research, scientific investigations, seek methods of medical care or provide for the treatment of patients.

§ 803. Gender-specific questions on grant applications. In order to obtain reliable and comprehensive data on the health needs of women as well as to ensure that women's health needs are served, in developing grant applications and consistent with the objectives and nature of the studies and research project, the department of health shall include gender-specific questions to determine whether the research and studies will impact primarily men or women and whether there are significant differences between the sexes in the outcome of the research or studies.

For purposes of this section, studies and research shall mean any studies or research for which the department of health provides funds. It shall not apply to any grant for which there are contrary indications in federal regulations.

ARTICLE 9

PRIMARY CARE EDUCATION AND TRAINING

Section 900. Short title.

901. Definitions.

902. Grants for primary care undergraduate medical education.

903. Primary care physician loan repayment program.

904. Primary care practitioner scholarship program.

905. Grants for primary care practitioner education.

906. Grants for minority participation in medical education.

907. Reports.

§ 900. Short title. This article shall be known and may be cited as the "primary care education and training act."

§ 901. Definitions. The following words or phrases as used in this article shall have the following meanings:

1. "Continuity experience" means that site where a resident spends at least twenty percent of his or her training providing primary care services to a panel of patients who are followed by such resident throughout his or her training.

2. "Council" means the New York state council on graduate medical education.

3. "President" means the president of the New York state higher education services corporation.

4. "Primary care practitioner program" means a full or part-time graduate, undergraduate or certificate course of study, approved or registered by the regents or a program registered by the department of education or determined by the department of education to be the equivalent required to practice as a licensed or certified primary care practitioner.

5. "Primary care medical training program" means a graduate medical education training program in New York state defined by the commissioner, in consultation with the council, pursuant to regulations, as providing appropriate training in primary care medicine.

6. "Underserved area" means an area or medically underserved population designated by the commissioner pursuant to regulation, and in consultation with the respective health systems agency, as having a shortage of primary care physicians or primary care practitioners.

7. "Primary care practitioner" means a midwife, nurse practitioner, or physician assistant who is licensed or certified to practice in New York state and who provides or arranges for coordinated primary care services.

8. "Primary care physician" means a physician specialist in the field of family practice, general pediatrics, primary care internal medicine or primary care obstetrics and gynecology; who provides coordinated primary care services.

§ 902. Grants for primary care undergraduate medical education. 1. The commissioner, in collaboration with the commissioner of education, is authorized, within amounts available pursuant to subdivision nineteen-a of section twenty-eight hundred seven-c of this chapter, to make grants to medical schools located in New York state in order to enhance the study of primary care, to increase the opportunities for undergraduate medical education in primary care at community-based sites and encourage the training of primary care physicians.

2. Grant proceeds may be used for faculty development; costs incurred teaching medical students at community-based sites, including, but not limited to, personnel, administration, and student-related expenses; expansion or development of programs that train primary care physicians; and other innovative programs designed to increase the number of medical students choosing primary care.

3. Such grants shall be awarded on a competitive basis in amounts not to exceed five hundred thousand dollars through a request for application process. In making awards, consideration shall be given to applicants who:

- (a) apply in collaboration with community-based providers;
- (b) make complementary efforts to enhance their curriculum in primary care;
- (c) make complementary efforts to recruit qualified faculty in primary care education;
- (d) make complementary efforts to reduce the percentage of students graduating in non-primary care specialties; and
- (e) make complementary efforts to match such award from funds raised through non-public sources.

4. The intent of this program is to augment or increase primary care undergraduate medical training. Grant funding shall not be used to offset existing expenditures that the medical school has obligated or intends to obligate for primary care training programs.

§ 903. Primary care physician loan repayment program. 1. The commissioner, in collaboration with the commissioner of education and the president of the higher education services corporation, is authorized and directed to establish a physician loan repayment program to encourage medical students to enter primary care specialties and to serve underserved areas and populations.

2. The commissioner is authorized, within amounts available pursuant to subdivision nineteen-a of section twenty-eight hundred seven-c and section twenty-eight hundred seven-l of this chapter, to make loan repayment awards as follows:

(a) beginning January first, nineteen hundred ninety-four, to any resident who first entered a primary care medical training program on or after January first, nineteen hundred ninety-four in the second or third year of such program; provided such resident agrees to practice primary care in an underserved area in New York state for one year for each such annual award received, with such practice beginning immediately after completion of such residency training. Such resident shall be eligible for an award of up to ten thousand dollars per year and beginning January first, nineteen hundred ninety-seven of up to fifteen thousand dollars per year; and

(b) beginning January first, nineteen hundred ninety-five, to a primary care physician, emergency medicine physician or other physician specialty determined by the commissioner to be in short supply, licensed to practice medicine in New York state, who agrees to practice for at least two years in an underserved area. Such physician shall be eligible for a loan repayment award of up to ten thousand dollars per year and beginning January first, nineteen hundred ninety-seven of up to fifteen thousand dollars per year for each of the first two years of practice in such area; provided, however, if such physician agrees to practice for an additional two years in such area, then such physician shall be

eligible for an award of up to fifteen thousand dollars per year and beginning January first, nineteen hundred ninety-seven of up to twenty thousand dollars per year for each of the second two years of such practice.

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

4. Within such time as the commissioner shall by regulation provide, a recipient of an award shall have practiced as a primary care physician in an underserved area in the state of New York or, in the case of a recipient of an award after completion of residency training, the recipient shall have practiced in an underserved area for that number of months calculated by multiplying by twelve the number of annual awards received by the recipient. If a recipient fails to comply fully with such conditions, the president shall be entitled to receive from such recipient an amount to be determined by the formula:

$$A = 2B(t-s)$$

t

In which "A" is the amount the president is entitled to recover, "B" is the sum of all payments made to the recipient and the interest on such amount which would be payable if at the times such awards were paid they were loans bearing interest at the maximum prevailing rate; "t" is the total number of months in the recipient's period of obligated services; and "s" is the number of months of services actually rendered by the recipient. Any amount which the president is entitled to recover under this subdivision shall be paid within the five-year period beginning on the date that the recipient failed to comply with this condition. Any obligation to comply with such provisions shall be canceled upon the death of the recipient. The commissioner of health shall promulgate regulations to provide for the waiver or suspension of any financial

obligation when compliance would involve extreme hardship.

5. The commissioner is authorized to apply any funds available for purposes of subdivision two of this section for use as matching funds for federal grants for the purpose of assisting states in operating loan repayment programs pursuant to section three hundred thirty-eight I of the public health service act.

6. The commissioner, in consultation with the council, shall promulgate regulations necessary to effectuate the provisions and purposes of this section.

§ 904. Primary care practitioner scholarship program. 1. The commissioner, in collaboration with the commissioner of education and the president of the higher education services corporation, is authorized and directed to establish a primary care practitioner scholarship program to provide financial support to applicants to enter or continue in a primary care practitioner program and who agree to serve in underserved areas of New York state.

2. The commissioner is authorized, within amounts available pursuant to subdivision nineteen-a of section twenty-eight hundred seven-c and section twenty-eight hundred seven-l of this chapter, to make scholarship awards pursuant to this section.

3. A scholarship recipient shall (a) be a resident of New York state who attends or plans to attend a primary care practitioner program; and (b) agree to practice as a primary care practitioner in an underserved area of New York state.

4. In selecting students to be awarded scholarships, preference shall be given to students who attend or plan to attend a primary care practitioner program located in New York state. Priority in the selection of recipients shall be given to recipients applying for second year funding. Scholarships shall be awarded competitively using selection criteria that include, but are not limited to: academic

performance, previous work experience in their chosen profession, and a demonstrated interest or commitment in working with underserved populations or in underserved areas.

5. Within such time as the commissioner shall by regulation provide, a recipient of an award shall agree to practice in an underserved area of this state for a period of eighteen months for each annual award to be received by the recipient. In no case shall the total number of months of service be less than eighteen. The commissioner shall secure from each recipient a written agreement to:

(a) provide primary care services in an area designated as having a shortage of primary care practitioners;

(b) work in a practice site that accepts payment on behalf of beneficiaries of title XVIII of the federal social security act (medicare) and individuals eligible for medical assistance pursuant to title eleven of article five of the social services law; and

(c) provide thirty-five hours per week of direct patient care in the designated shortage area being served.

6. If a recipient fails to comply fully with such conditions, the president shall be entitled to receive from such recipient an amount to be determined by the formula:

$$A = 2B(t-s)$$

t

in which "A" is the amount the president is entitled to recover, "B" is the sum of all awards made to the recipient and the interest on such amount which would be payable if at the times such awards were paid they were loans bearing interest at the maximum prevailing rate; "t" is the total number of months in the recipient's period of obligated services; and "s" is the number of months of service actually rendered by the recipient. Any amount which the president is entitled to recover under this paragraph shall be paid within the five-year period beginning on the date that the recipient failed to comply with this service condition. Nothing in the written agreement shall affect the terms of employment of the individual who shall negotiate, separate and apart from the program, his or her salary and other forms of employment with

an agency, institution or a program in which he or she shall be employed. Any obligation to comply with such provisions as outlined in this section shall be canceled upon the death of the recipient. The commissioner shall promulgate regulations to provide for the waiver or suspension of any financial obligation when compliance would involve extreme hardship.

7. A recipient of an award shall report annually to the New York state higher education services corporation, on forms prescribed by the president, as to the performance of the required services, commencing with the calendar year in which the recipient begins to provide primary care services in an underserved area and continuing until the recipient shall have completed, or until it is determined that he or she shall not be obligated to complete, the required services. If the recipient shall fail to file any report required hereunder within thirty days of written notice to the recipient, mailed to the address shown on the last application for an award or last report filed, whichever is later, the president of the corporation may impose a fine of up to one thousand dollars. The president shall have the discretion to waive the filing of a report, excuse a delay in filing or a failure to file a report, or waive or reduce any fine imposed for good cause shown.

8. The commissioner is authorized to apply any funds available for purposes of subdivision two of this section for use as matching funds for the federal community scholarship programs grants pursuant to section three hundred thirty-eight L of the public health service act.

§ 905. Grants for primary care practitioner education. 1. The commissioner in collaboration with the commissioner of education is authorized, within amounts available pursuant to subdivision nineteen-a of section twenty-eight hundred seven-c of this chapter, to make grants to colleges, universities or hospital-based training programs within New York state to establish or expand training programs for nurse practitioners, physician assistants or midwives, and to increase the opportunities for practitioner education in primary care at community-based sites.

2. Grant funds may be used for administration, faculty recruitment and development, start-up costs and costs incurred teaching primary care practitioners at community-based sites, including, but not limited to, personnel, administration and student related expenses and other expenses judged reasonable and necessary by the commissioner.

3. Grants shall be awarded on a competitive basis in amounts not to exceed two hundred fifty thousand dollars through a request for application process. In making awards, the commissioner shall consider:

(a) the need for primary care practitioners in the region in which the applicant is located;

(b) the cost-effectiveness of the proposal; and

(c) the applicant's commitment to place graduates in primary care settings and/or underserved areas.

4. The intent of the program is to augment or increase training programs for nurse practitioners, physician assistants and midwives. Grant funding shall not be used to offset existing expenditures the institution or program has obligated or intends to obligate for such training programs.

§ 906. Grants for minority participation in medical education. 1. The commissioner, in collaboration with the commissioner of education, within amounts available pursuant to subdivision nineteen-a of section twenty-eight hundred seven-c and section twenty-eight hundred seven-l of this chapter, is authorized to make grants to encourage minority participation in medicine.

2. Grants shall be awarded through a request for application process for the following purposes:

to medical schools located in New York state or primary care medical training programs to encourage minority participation in medical education, which may include programs to enhance minority recruitment and retention, minority student mentoring programs, development of

medical career pathways for minority students, and development of minority faculty role models.

3. The intent of this program is to augment or increase minority participation in medical education. Grants funding shall not be used to offset existing expenditures which the grantee has obligated for minority participation in medical education.

§ 907. Reports. The commissioner, in conjunction with the commissioner of education, shall prepare and submit a report to the governor and the legislature, due on February first, nineteen hundred ninety-five, reporting the results and evaluating the effectiveness of the New York state primary care education and training act, including recommendations for the placement of primary care physicians and primary care practitioners in underserved areas.

ARTICLE 9-A

NEW YORK STATE SMALL BUSINESS HEALTH INSURANCE PARTNERSHIP PROGRAM

Section 921. Definitions.

922. New York state small business health insurance partnership program.

§ 921. Definitions. For the purposes of this article, unless the context clearly requires otherwise:

1. "Applicant" means an eligible employer which submits an application under subdivision two of section nine hundred twenty-two of this article.

2. "Eligible employer" means a sole proprietor or an employer of between one and fifty full-time employees, who has not within the twelve-month period prior to the effective date of this section provided group health insurance benefits to any employee associated with the employers' business.

3. "Small business health insurance partnership program" means a program which assists employers in providing health care coverage under subdivision two of section nine hundred twenty-two of this article.

4. "Small group health insurance policy" means a group health insurance policy or comprehensive health services plan issued on a community-rated, open-enrolled basis pursuant to article thirty-two or forty-three of the insurance law by an insurer licensed pursuant to article forty-one or forty-two of the insurance law, a corporation organized pursuant to article forty-three of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law; provided, however, in no event shall premiums be used to purchase riders to policies or to purchase non-comprehensive policies.

5. "Incentive payment" means the payment of the portion of the premium for a small group health insurance policy obtained through the small business health insurance partnership program.

6. "Partnership certificate" means a certificate evidencing the approval of an application from an eligible employer which is issued prior to January first, two thousand.

7. "Full-time employee" means an employee who works twenty or more hours per week.

§ 922. New York state small business health insurance partnership program. 1. The commissioner is authorized to the extent of funds available therefor to establish the New York state small business health insurance partnership program.

2. New York state small business health insurance partnership program. (a) A small business health insurance partnership program shall assist eligible employers in purchasing small group health insurance policies for their full-time employees and dependents.

(b) An eligible employer may apply to the commissioner for approval in the small business health insurance partnership program by submitting an application on a form prescribed by the commissioner. The information required on such application shall include, but not be limited to:

(i) the name and address of the employer and the nature of the business;

(ii) the names and salaries of the employer and employees;

(iii) an affidavit by the employer that employer-provided health insurance benefits have not been provided to employees in the twelve-month period prior to the effective date of this article; and

(iv) such other information as the commissioner may require.

(c) Upon reviewing the applications from eligible small employers, the commissioner shall, within the amount appropriated for such purpose, award partnership certificates to employers which meet the eligibility requirements; provided however, no partnership certificates will be awarded by the commissioner on and after January first, two thousand. In addition to evidencing approval of an eligible employer, the certificate shall state the amount of a small business health insurance partnership incentive payment for a small group health insurance policy, which in no event may exceed forty-five percent of the premium costs for group health care coverage for employees and their dependents. Employees may be required to make contributions to the payment of premium costs under this program at the option of the employer, but in no event shall such contribution exceed ten percent of the premium costs. Premium costs incurred by an employer for small group health insurance coverage for officers and directors of an employer and others with a proprietary or ownership interest in the employer may be eligible for an incentive payment to offset premium costs; provided, however, that the gross household income of such officers and directors or others with a proprietary or ownership interest is at or below two hundred twenty-two percent of the non-farm federal poverty level and provided further that one or more employees and their dependents proposed to be covered by such group health care coverage are unrelated to such officers, directors or other persons with a proprietary or ownership interest. If after joining the program an employer participating in a small business insurance partnership program hires more employees so that the employer has more than fifty full-time employees at any one time, the employer

may continue in the program but the premium costs attributable to the additional employees in excess of fifty or their families shall not be eligible for incentive payments.

(d) In approving partnership certificates for eligible small employers prior to January first, two thousand, the commissioner shall:

(i) first approve applications from eligible employers currently receiving assistance through a small business health insurance program created by the expanded health care coverage act authorized pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight; and

(ii) give preference to eligible employers with the lowest average salaries and base the amount of the certificate on the salaries received by the employer and employees in order to maximize the impact of the small business partnership premium payments.

(e) Upon receipt of a partnership certificate from the commissioner, an approved eligible employer may obtain a small group health insurance policy from the insurer, health maintenance organization or corporation of its choice. No such insurer, health maintenance organization or corporation shall refuse to accept a small employer holding a valid partnership certificate and such insurer, organization or corporation shall arrange for the payment of the small employer's share of the small group health insurance policy or comprehensive health services plan premium. The approved applicant shall make available upon request from the commissioner information regarding continued eligibility in the program.

The commissioner shall, within amounts available therefor, on a competitive bid process, contract with organizations for purposes of public education, outreach and recruitment of eligible businesses, including the distribution of applications and information regarding enrollment. The organizations shall include, but not be limited to: community based organizations such as chambers of commerce or trade organizations, diagnostic and treatment centers, hospitals, and other such organizations which engage in outreach and marketing activities. In no event shall the amount available for education, outreach, and recruitment exceed two percent of the total amount available for the purposes of this section.

(f) The commissioner, by rules and regulations, adopted by the commissioner shall establish the procedure by which insurers, corporations and organizations issuing small group health insurance policies under this article may redeem a certificate or certificates for the portion of the premium not paid by the employer, but in no event shall such redemption occur on less than a quarterly basis.

Any business which, with the intent to obtain benefits, willfully misstates information required for application for participation in the New York state health insurance partnership program or willfully fails to notify the commissioner or the commissioner's designee of any change in status which makes the business ineligible for the program, shall repay such incentive payments paid on behalf of its employees or program participants for health coverage through the New York state health insurance partnership program.

(g) Notwithstanding any inconsistent provision of law or regulation to the contrary, benefits under the small business health insurance partnership program shall be considered secondary to any other plan of insurance or benefit program under which a person may have coverage.

(h) On or before April first, nineteen hundred ninety-seven, and annually thereafter through April first, two thousand, the commissioner shall submit a report on the small business health insurance partnership program to the governor, the speaker of the assembly and the majority leader of the senate. Such report shall include, but not be limited to:

(i) the number of employers and employees able to purchase small group health insurance policies under the program;

(ii) the location and the nature of the business of such employers;
and

(iii) recommendations for any changes which would improve the program.

ARTICLE 9-B

PRIMARY CARE SERVICE CORPS PRACTITIONER LOAN REPAYMENT PROGRAM

Section 923. Definitions.

924. Primary care service corps practitioner loan repayment program.

§ 923. Definitions. The following words or phrases as used in this section shall have the following meanings:

1. "Underserved area" means an area or medically underserved population designated by the commissioner as having a shortage of primary care physicians, other primary care practitioners, dental practitioners or mental health practitioners.

2. "Primary care service corps practitioner" means a physician assistant, nurse practitioner, midwife, general or pedodontic dentist, dental hygienist, clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, licensed marriage and family therapist, or a licensed mental health counselor, who is licensed, registered, or certified to practice in New York state and who provides coordinated primary care services, including, but not limited to, oral health and mental health services and meets the national health service corps state loan repayment program eligibility criteria.

3. "Physician assistant" means a person who has been registered as such pursuant to article one hundred thirty-one-B of the education law and meets the national health service corps state loan repayment program eligibility criteria.

4. "Nurse practitioner" means a person who has been certified as such pursuant to section sixty-nine hundred ten of the education law and meets the national health service corps state loan repayment program eligibility criteria.

5. "Midwife" means a person who has been licensed as such pursuant to section sixty-nine hundred fifty-five of the education law and meets the national health service corps state loan repayment program eligibility criteria.

6. "Psychologist" means a person who has been licensed as such pursuant to section seventy-six hundred three of the education law and

meets the national health service corps state loan repayment program eligibility criteria.

7. "Licensed clinical social worker" means a person who has been licensed as such pursuant to section seventy-seven hundred two of the education law and meets the national health service corps state loan repayment program eligibility criteria.

8. "Psychiatric nurse practitioner" means a nurse practitioner who, by reason of training and experience, provides a full spectrum of psychiatric care, assessing, diagnosing, and managing the prevention and treatment of psychiatric disorders and mental health problems and meets the national health service corps state loan repayment program eligibility criteria.

9. "Licensed marriage and family therapist" means a person who has been licensed as such pursuant to section eighty-four hundred three of the education law and meets the national health service corps state loan repayment program eligibility criteria.

10. "Licensed mental health counselor" means a person who has been licensed as such pursuant to section eighty-four hundred two of the education law and meets the national health service corps state loan repayment program eligibility criteria.

11. "General or pedodontic dentist" means a person who has been licensed or otherwise authorized to practice dentistry pursuant to article one hundred thirty-three of the education law excluding orthodontists, endodontists and periodontists and meets the national health service corps state loan repayment program eligibility criteria.

12. "Dental hygienist" means a person who is licensed to practice dental hygiene pursuant to section sixty-six hundred nine of the education law and meets the national health service corps state loan repayment program eligibility criteria.

§ 924. Primary care service corps practitioner loan repayment program.

1. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, the commissioner is authorized, within amounts available therefor, to make loan repayment awards to eligible primary care service corps practitioners who agree to practice full-time in an underserved area in New York state, in amounts to be determined by the commissioner, but not to exceed thirty-two thousand dollars per year for any year in which such practitioners provide full-time eligible obligated service, without competitive bid or request for proposal process.

2. Loan repayment awards made to a primary care service corps practitioner pursuant to subdivision one of this section shall not exceed the total qualifying outstanding debt of the practitioner from student loans to cover tuition and other related educational expenses, made by or guaranteed by the federal or state government, or made by a lending or educational institution approved under title IV of the federal higher education act. Loan repayment awards shall be used solely to repay such outstanding debt.

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

4. The commissioner is authorized to apply any funds available for purposes of subdivision one of this section for use as matching funds for any available federal grants for the purpose of assisting states in operating loan repayment programs.

5. The commissioner may postpone, change or waive the service obligation and repayments amounts set forth in subdivisions one and three of this section, respectively, in individual circumstances where there is compelling need or hardship.

6. In order to be eligible to receive a loan repayment award under this section, a primary care service corps practitioner must meet site and service eligibility criteria as determined by the commissioner.

7. The commissioner shall promulgate regulations necessary to effectuate the provisions and purposes of this article.

ARTICLE 11

PUBLIC WATER SUPPLIES; SEWERAGE AND SEWAGE CONTROL

- Title I. Potable waters (§§ 1100--1114-b).
- II. Realty subdivisions: water supply (§§ 1115-1120).
- II-A. Water Supply Emergency Plans (§ 1125).
- III. Annual water supply statement (§§ 1150-1153).
- IV. Drinking water revolving fund (§§ 1160-1169).

TITLE I

POTABLE WATERS

- Section 1100. Rules and regulations of the department.
- 1100-a. Fluoridation.
- 1101. Inspection.
- 1102. Violation; injunction and abatement.
- 1103. Violation; penalties.
- 1104. Sewage removal or purification; condemnation of property.
- 1105. Sewage removal or purification; rights of property owners.
- 1106. Limitations; city of New York.
- 1107. Orders of commissioner.
- 1108. Powers and duties with respect to comprehensive public water supply planning.
- 1109. Standards for water reuse.
- 1110. School potable water testing and standards.
- 1112. Emerging contaminant monitoring.
- 1113. Drinking water quality council; established.

- 1114. Lead service line replacement grant program.
- 1114-a. Voluntary public water system consolidation study.
- 1114-b. Service line inventories and mapping.

§ 1100. Rules and regulations of the department. 1. The department may make rules and regulations for the protection from contamination of any or all public supplies of potable waters and water supplies of the state or United States, institutions, parks, reservations or posts and their sources within the state, and the commissioner of environmental protection of the city of New York and the board of water supply of the city of New York may make such rules and regulations subject to the approval of the department for the protection from contamination of any or all public supplies of potable waters and their sources within the state where the same constitute a part of the source of the public water supply of said city.

2. Every such rule or regulation shall be published at least once in each week for two consecutive weeks, in at least one newspaper of the county where the waters to which it relates are located. The cost of such publication shall be paid by the corporation, municipality, state or United States or state or United States institution, park, reservation or post benefited by the protection of the water supply to which the rule or regulation published relates.

3. The affidavit of the printer, publisher or proprietor of the newspaper in which such rule or regulation is published shall be filed, together with the rule or regulation published, in the county clerk's office of such county, and such affidavit and rule and regulation shall be conclusive evidence of such publication, and of all the facts therein stated in all courts and places.

4. All rules and regulations heretofore duly made and published for the sanitary protection of public water supplies, pursuant to chapter five hundred forty-three of the laws of eighteen hundred eighty-five, and chapter six hundred sixty-one of the laws of eighteen hundred ninety-three, as amended, are hereby legalized, ratified, confirmed and

continued in force, until new rules and regulations become operative.

5. This section shall not be construed to repeal or affect any of the provisions of chapter three hundred seventy-eight of the laws of eighteen hundred ninety-seven, or its amendments.

§ 1100-a. Fluoridation. 1. Notwithstanding any contrary provision of law, rule, regulation or code, any county, city, town or village that owns both its public water system and the water supply for such system may by local law provide whether a fluoride compound shall be added to such public water supply.

2. Any county, wherein a public authority owns both its public water system and the water supply for such system, may by local law provide whether a fluoride compound shall be added to such public water supply.

3. No county, city, town or village, including a county wherein a public authority owns both its public water system and the water supply for such system, that fluoridates a public water supply or causes a public water supply to be fluoridated, shall discontinue the addition of a fluoride compound to such public water supply unless it has first complied with the following requirements:

(a) issue a notice to the public of the preliminary determination to discontinue fluoridation for comment, which shall include the justification for the proposed discontinuance, alternatives to fluoridation available, and a summary of consultations with health professionals and the department concerning the proposed discontinuance. Such notice may, but is not required to, include publication in local newspapers. "Consultations with health professionals" may include formal studies by hired professionals, informal consultations with local public health officials or other health professionals, or other consultations, provided that the nature of such consultations and the identity of such professionals shall be identified in the public notice. "Alternatives to fluoridation" may include formal alternatives provided by or at the expense of the county, city, town or village, or other alternatives available to the public. Any public comments received in response to

such notice shall be addressed by the county, city, town or village in the ordinary course of business; and

(b) provide the department at least ninety days prior written notice of the intent to discontinue and submit a plan for discontinuance that includes but is not limited to the notice that will be provided to the public, consistent with paragraph (a) of this subdivision, of the determination to discontinue fluoridation of the water supply, including the date of such discontinuance and alternatives to fluoridation, if any, that will be made available in the community, and that includes information as may be required under the Sanitary Code.

4. The commissioner is hereby authorized, within amounts appropriated therefor, to make grants to counties, cities, towns or villages that own their public water system and the water supply for such system, including a county wherein a public authority owns both its public water system and the water supply for such system, for the purpose of providing assistance towards the costs of installation, including but not limited to technical and administrative costs associated with planning, design and construction, and start-up of fluoridation systems, and replacing, repairing or upgrading of fluoridation equipment for such public water systems. Grant funding shall not be available for assistance towards the costs and expenses of operation of the fluoridation system, as determined by the department. The grant applications shall include such information as required by the commissioner. In making the grant awards, the commissioner shall consider the demonstrated need for installation of new fluoridation equipment or replacing, repairing or upgrading of existing fluoridation equipment, and such other criteria as determined by the commissioner. Grant awards shall be made on a competitive basis and be subject to such conditions as may be determined by the commissioner.

§ 1101. Inspection. 1. The person, officer, board or commission having the management and control of the potable water supply of any municipality, state or United States institution, park, reservation or post, and in the city of New York, the commissioner of environmental protection, and the board of water supply of the city of New York, or

the corporation furnishing such supply, may make such inspection of the sources of such water supply as such person, officer, board, corporation or commission deems advisable and to ascertain whether the rules or regulations of the department, and of the commissioner of environmental protection of the city of New York, and of the board of water supply of the city of New York, are complied with, and shall make such regular or special inspections as the commissioner, or the commissioner of environmental protection of the city of New York, or the board of water supply of the city of New York, may prescribe.

2. The authorities in charge of the water supply or their duly authorized representatives may without fee or hindrance, enter, examine and survey all grounds, structures, buildings and places on the watershed tributary to the sources of such water supply in order to ascertain whether such rules or regulations are complied with.

§ 1102. Violation; injunction and abatement. 1. If any inspection discloses a violation of any rule or regulation promulgated pursuant to section one thousand one hundred of this chapter relating to a temporary or permanent source or act of contamination, the person, officer, board, or commission having the management and control of the potable water supply of the municipality, state or United States institution, park, reservation or post, and in the city of New York, the commissioner of environmental protection, and the board of water supply of the city of New York, or the corporation furnishing such supply shall cause a copy of the rule or regulation violated to be served upon the person violating the same, with a notice of such violation. If the person served does not comply immediately with the rule or regulation violated, such person, officer, board, corporation or commission, except in a case concerning the violation of a rule or regulation relating to a temporary or permanent source or act of contamination affecting the potable water supply of the city of New York, shall notify the department of the violation.

2. (a) Upon being notified of any violation as herein provided, the department shall examine immediately into such violation; and if the

department finds such rule or regulation to have been violated, the commissioner shall order the local board of health of the health district wherein the violation or noncompliance occurs, to convene and enforce compliance with such rule or regulation.

(b) If the local board of health of the health district wherein the violation or noncompliance occurs, fails to enforce the order of the commissioner within ten days after its receipt, the corporation furnishing such water supply or the municipality, state, or United States or state or United States institution, park, reservation or post deriving its water supply from the waters to which such rule or regulation relates, or the commissioner, or the local board of health of the health district wherein the water supply protected by these rules is used, or any person interested in the protection of the purity of the water supply, may maintain an action in a court of record which shall be tried in the county where the cause of action arose against such person, for the recovery of the penalties incurred by such violation, and for an injunction restraining the person violating such rule or regulation from the continued violation thereof.

3. (a) If the person served with notice of violation does not comply within five days with the rule or regulation violated, in case such rule or regulation relates to a temporary or permanent source or act of contamination affecting the potable water supply of the city of New York, the commissioner of environmental protection of said city, or the board of water supply of the city of New York, may summarily enforce compliance with such rule or regulation and may summarily abate or remove the cause of the violation of such rule or regulation or the nuisance so created, and to that end may employ such force as may be necessary and proper; provided, however, that no building or improvement shall be removed, disturbed or destroyed by the said commissioner of environmental protection or the said board of water supply until he or they shall cause measurements to be made of the buildings and photographs of the exterior views thereof, which measurements and photographs shall be at the disposition thereafter of the owners or their attorneys, and failure to exercise such right of abatement shall not be deemed a waiver thereof.

(b) Failure to comply within five days with such rule or regulation

shall further entitle the city of New York to maintain an action in any court having jurisdiction thereof for the recovery of the penalties incurred by such violation in an amount authorized by section one thousand one hundred three of this title and for an injunction restraining the person from violating such rule or regulation, or creating or continuing such nuisance. The remedy by abatement herein provided for shall not be construed to be exclusive.

§ 1103. Violation; penalties. 1. If a person or entity willfully violates any rule or regulation promulgated pursuant to section one thousand one hundred of this title relating to a temporary or permanent source or act of contamination, such person or entity violating such rule or regulation shall be liable to prosecution for a misdemeanor for every such violation, and on conviction thereof shall be punished by a fine not exceeding one thousand dollars, or imprisonment not exceeding one year, or both.

2. If a person or entity violates any rule or regulation promulgated pursuant to section one thousand one hundred of this title relating to a temporary or permanent source or act of contamination, the department may impose a civil penalty for the violation thereof or the noncompliance therewith, not exceeding two hundred dollars for every such violation or noncompliance.

3. For purposes of calculating the applicable civil penalty under this section, each day on which such violation occurred may be considered a separate incident. In addition, a court may order such person or entity to make reparations for any permanent and/or substantial damage caused as a direct result of such violation. For purposes of subdivision one of this section, restitution and reparation may be ordered in accordance with applicable provisions of the criminal procedure law.

§ 1104. Sewage removal or purification; condemnation of property. 1. When the department or the commissioner of environmental protection of the city of New York, or the board of water supply of the city of New

York, shall, for the protection of a water supply from contamination, makes orders or regulations the execution of which will require or make necessary the construction and maintenance of any system of sewerage, or a change thereof, in or for any village or hamlet, whether incorporated or unincorporated, or the execution of which will require the providing of some public means of removal or purification of sewage, the municipality, corporation, state or United States or state or United States institution, park, reservation or post owning the waterworks benefited thereby shall, at its own expense, construct and maintain such system of sewerage, or change thereof, and provide and maintain such means of removal and purification of sewage and such works or means of sewage disposal as shall be approved by the department. For such purpose said municipality, corporation, state or United States or state or United States institution, park, reservation or post, may acquire, by condemnation the necessary real estate or interest therein or the easement or use thereof whether now used for public or private purposes.

2. When the execution of any such regulations of the department, or the commissioner of environmental protection of the city of New York, or the board of water supply of the city of New York will occasion or require the removal of any building or buildings, the municipality, corporation, state or state institution, park, reservation or post owning the waterworks benefited thereby shall, at its own expense, remove such buildings and pay to the owner thereof all damages occasioned by such removal.

3. When the execution of any such regulation will injuriously affect any property the municipality, corporation, state or state institution, park, reservation or post owning the waterworks benefited thereby shall make just and adequate compensation for the property so taken or injured and for all injuries caused to the legitimate use of operation of such property.

4. Until such construction or change of such system or systems of sewerage, and the providing of such means of removal or purification of sewage, and until such works or means of sewage disposal and the removal of any buildings are so made by the municipality, corporation, state or

state institution, park, reservation or post owning the waterworks to be benefited thereby at its own expense, and until, except in the case of a municipality, state or state institution, park, reservation or post, the corporation owning the waterworks benefited shall make just and adequate payment for all injuries to property and for all injuries caused to the legitimate use or operation of such property, there shall be no action or proceeding taken by any such municipality, officer, board, person, commission or corporation against any person or corporation for the violation of any regulation of the department under this article, and no person or corporation shall be considered to have violated or refused to obey any such rule or regulation.

§ 1105. Sewage removal or purification; rights of property owners. 1. The owner of any building the removal of which is occasioned or required, or which has been removed by any rule or regulation of the department, or the commissioner of environmental protection of the city of New York, or the board of water supply of the city of New York, made under the provisions of this article, and all persons whose rights of property are injuriously affected by the enforcement of any such rule or regulation, shall have a cause of action against the municipality or corporation, and shall have the right to present a claim against and to the state or state institution, park, reservation or post owning the waterworks benefited by the enforcement of such rule or regulation, for all damages occasioned or sustained by such removal or enforcement, including all injuries caused to the legitimate use or operation of such property.

2. (a) An action for such damages may be brought against such municipality or corporation in accordance with the provisions of the eminent domain procedure law.

§ 1106. Limitations; city of New York. Nothing contained in this chapter shall extend the sanitary control of the board of water supply of the city of New York, beyond the sources of potable water supply, tributary to the Catskill and Delaware aqueducts; and the powers granted

by this chapter to the board of water supply of the city of New York shall cease at the time of the transference of the jurisdiction over the source of water supply, by the board of water supply to the commissioner of environmental protection of the city of New York; and at no time shall the commissioner of environmental protection of the city of New York and the board of water supply of said city have or exercise concurrent powers or sanitary control over any source of potable water supply tributary to the Catskill or Delaware aqueduct.

§ 1107. Orders of commissioner. 1. When the commissioner, after investigation of the condition of any public water supply used for drinking or other domestic purposes, whether maintained and operated by a municipality, water district or private corporation, company or individual, shall certify to the board, corporation, company, officer or person in charge of the maintenance and operation of such water supply that in his opinion such water supply is so polluted or subject to dangerous pollution or so inadequate or of such objectionable physical quality as to constitute a menace to the public health and shall order reasonable improvements to be made for the protection of public health and such municipality, water district or private corporation, company or individual maintaining and operating such water supply shall fail to carry out such order forthwith, any court of competent jurisdiction may, upon the application of the commissioner, enforce prompt compliance with such order.

2. Service of the certificate by the commissioner as aforesaid shall be made upon the mayor or corporation counsel of the municipality or upon an officer of the water district or private corporation or company as the case may be.

3. The commissioner shall promulgate regulations to provide for immediate public notice, in a manner prescribed by such regulations, of the existence of a public health hazard concerning any public water supply.

§ 1108. Powers and duties with respect to comprehensive public water supply planning. The commissioner shall perform such duties and functions with respect to comprehensive public water supply planning as are provided in part five-A of article five of the conservation law, and shall have such powers and authority as may be necessary in that regard.

§ 1109. Standards for water reuse. 1. The commissioner shall advise the department of environmental conservation on the establishment of rules, regulations and standards for the reuse and disposal of reclaimed wastewater and/or greywater. Such advice shall include, but not be limited to, advice on water quality and pathogens monitoring requirements for each permitted use of reclaimed wastewater and greywater.

2. For the purposes of this section, the terms "greywater" and "reclaimed wastewater" shall have the same meaning as set forth in section 15-0601 of the environmental conservation law.

§ 1110. School potable water testing and standards. 1. In addition to school districts already classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations, as such regulations may, from time to time, be amended, every school district and board of cooperative educational services shall conduct triennial first-drawn tap testing of potable water systems to monitor for lead contamination in each occupied school building under its jurisdiction as required by regulations promulgated pursuant to this section. The testing shall be conducted and the results analyzed by an entity or entities approved by the commissioner.

2. Where a finding of lead contamination is made, the affected school district shall: (a) continue first-drawn tap water testing pursuant to regulations promulgated pursuant to this section; (b) provide school occupants with an adequate supply of safe, free to the school occupants, potable water for drinking as required by rules and regulations of the department until future tests indicate lead levels pursuant to

regulations promulgated pursuant to this section; and (c) provide parents or persons in parental relation to a child attending said school with written notification of test results.

3. The commissioner, in consultation with the commissioner of education, shall promulgate regulations to carry out the provisions of this section. Notwithstanding any other provision of law to the contrary, the regulations promulgated with regard to lead levels shall be consistent with the requirements for those school districts classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations as such regulations may, from time to time, be amended; provided, however, that the lead action level is exceeded if the concentration of lead is greater than 0.005 milligrams per liter.

4. The commissioner may grant a waiver from the testing requirements of this section for certain school buildings, provided that the school district has substantially complied with the testing requirements and has been found to be below lead levels as determined by regulations promulgated pursuant to this section, as amended, for such buildings.

5. Each school district and board of cooperative educational services conducting testing pursuant to subdivision one of this section and each school district classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations, as such regulations may, from time to time, be amended, shall make a copy of the results of all such testing, including laboratory reports, and any lead remediation plans available to the public on its website and any additional means as chosen by such district. A copy of the results of all testing shall also be immediately transmitted to the department and state education department in a format to be determined by the commissioner and to the county department of health in the local jurisdiction of the school building. The commissioner of education, in conjunction with the commissioner, shall publish a report triennially based on the findings from the tap water testing conducted according to the provisions of this section. Such report shall be sent to the commissioner, the governor, the temporary president of the senate, and the speaker of the assembly

and shall be made available on the department's and state education department's websites.

6. Expenses for remediation under this section and any regulations promulgated thereto shall be fully reimbursable from funds appropriated through the department of environmental conservation for clean water infrastructure projects.

§ 1112. Emerging contaminant monitoring. 1. Industry and modern technology have created thousands of new chemicals that would not otherwise exist in nature. Although some of these chemicals have proven benefits, the effect of many such chemicals on human health is unknown or not fully understood. Furthermore, with the advance of science and technology, public health scientists and experts are able to identify naturally occurring contaminants that pose previously unknown hazards to human health. Where these chemicals or contaminants, collectively referred to as "emerging contaminants," enter drinking water supplies, they can present unknown but potentially serious risks to public health. New Yorkers served by public water supplies have the right to know when potentially hazardous substances contaminate their drinking water and the department must be equipped to monitor and protect the public from these emerging contaminants.

2. a. "Emerging contaminants" shall mean any physical, chemical, microbiological or radiological substance listed as an emerging contaminant pursuant to subdivision three of this section.

b. "Notification level" means the concentration level of an emerging contaminant in drinking water that the commissioner has determined, based on available scientific information, warrants public notification and may require actions, which may include enhanced monitoring and activities to reduce exposure, pursuant to this section.

c. "Covered public water system" shall mean: (i) a public water system that serves at least five service connections used by year-round residents or regularly serves at least twenty-five year-round residents;

or (ii) a public water system that regularly serves at least twenty-five of the same people, four hours or more per day, for four or more days per week, for twenty-six or more weeks per year.

3. a. The commissioner shall promulgate regulations to identify and list substances as emerging contaminants that meet the following criteria:

(i) are not subject to any other substance-specific drinking water regulation of the department that establishes a maximum contaminant level, maximum residual disinfectant level, or action level;

(ii) are known or anticipated to occur in public water systems; and

(iii) because of their quantity, concentration, or physical, chemical or infectious characteristics, may cause physical injury or illness, or otherwise pose a potential hazard to human health when present in drinking water.

b. In determining what substances shall be listed as emerging contaminants the commissioner shall, at a minimum, consider:

(i) unregulated contaminants monitored pursuant to the federal Safe Drinking Water Act (42 U.S.C. § 300g-1) as amended from time to time;

(ii) substances that require regulation or monitoring when present in drinking water in other jurisdictions outside the state of New York;

(iii) pesticide chemicals for which the United States environmental protection agency has set human health benchmarks for drinking water;

(iv) substances found at sites in remedial programs located inside and outside the state of New York, including but not limited to inactive hazardous waste sites; and

(v) recommendations from the drinking water quality council established pursuant to section eleven hundred thirteen of this title.

c. The commissioner shall, at a minimum, include the following chemicals identified as emerging contaminants in the first list of emerging contaminants: perfluorononanoic acid (PFNA); perfluorohexanesulfonic acid (PFHxS); perfluoroheptanoic acid (PFHpA); perfluorobutanesulfonic acid (PFBS); hexafluoropropylene oxide dimer acid (HFPO-DA); Perfluorodecanoic acid (PFDA); Perfluorododecanoic acid (PFDoA); Perfluorohexanoic acid (PFHxA); Perfluoroundecanoic acid

(PFUnA); 11-chloroeicosafluoro-3-oxaundecane-1-sulfonic acid (11Cl-PF30UdS); 9-chlorohexadecafluoro-3-oxanonane-1-sulfonic acid (9Cl-PF30NS); 4,8-dioxa-3H-perfluorononanoic acid (ADONA); Nonafluoro-3,6-dioxaheptanoic acid (NFDHA); Perfluorobutanoic acid (PFBA); 1H, 1H, 2H, 2H-Perfluorodecane sulfonic acid (8:2FTS); Perfluoro(2-ethoxyethane)sulfonic acid (PFEESA); Perfluoroheptanesulfonic acid (PFHpS); 1H,1H, 2H, 2H-Perfluorohexane sulfonic acid (4:2FTS); Perfluoro-3-methoxypropanoic acid (PFMPA); Perfluoro-4-methoxybutanoic acid (PFMBA); 1H,1H, 2H, 2H-Perfluorooctane sulfonic acid (6:2FTS); Perfluoropentanoic acid (PFPeA); Perfluoropentanesulfonic acid (PFPeS).

d. The commissioner shall make regulations to list the following additional substances as emerging contaminants; provided however the commissioner may, upon review and recommendation by the drinking water quality council pursuant to section eleven hundred thirteen of this title determine not to include such chemicals as emerging contaminants by January first, two thousand twenty-four: 1,2,3-trichloropropane; chloromethane (methylchloride); 1,1-dichloroethane; bromomethane (methyl bromide); chlorodifluoromethene (HCFC-22); vanadium; molybdenum; cobalt; strontium; chromium-6; N-ethyl perfluorooctanesulfonamidoacetic acid (NEtFOSAA); N-methyl perfluorooctanesulfonamidoacetic acid (NMeFOSAA); Perfluorotetradecanoic acid (PFTA); Perfluorotridecanoic acid (PFTrDA). Provided, however, the commissioner may, upon review and recommendation by the drinking water quality council, determine not to include such chemicals as emerging contaminants: testosterone; and 4-androstene-3, 17-dione.

e. The commissioner shall by regulation remove any substance from the list of emerging contaminants upon adopting a maximum contaminant level for such substance.

4. Every covered public water system shall test drinking water for the presence of emerging contaminants at least once every three years pursuant to a schedule determined by the department through regulation.

5. Every test conducted in accordance with this section shall be

conducted by a laboratory certified by the department pursuant to section five hundred two of this chapter. Laboratories shall submit such results electronically to the department, to any other health department with jurisdiction over the covered public water system, and to the covered public water system, in the manner prescribed pursuant to section five hundred two of this chapter.

6. The commissioner shall promulgate regulations establishing notification levels for any emerging contaminant listed pursuant to subdivision three of this section. Any notification level established pursuant to this subdivision shall be equal to or lower than any federal lifetime health advisory level established pursuant to the federal Safe Drinking Water Act (42 U.S.C. § 300g-1). If no federal lifetime health advisory level has been established, the commissioner shall establish notification levels based upon the available scientific information, and may take into consideration recommendations of the drinking water quality council established pursuant to section eleven hundred thirteen of this title. Such notification levels shall be made easily accessible to the public through a link that is posted on the department's website and updated regularly.

7. Notwithstanding subdivision three of this section, the commissioner may, by declaration, add any physical, chemical, microbiological or radiological substance to the list of emerging contaminants established pursuant to subdivision three of this section, establish a notification level, and require testing for such substance, if the commissioner determines that: (i) such substance poses or has the potential to pose a significant hazard to human health when present in drinking water; (ii) such substance was recently detected in a public water system and has the potential to be present in other public water systems; and (iii) it appears to be prejudicial to the interests of the people to delay action by preparing and filing regulations. The commissioner shall, however, promulgate regulations adding such new emerging contaminant or establishing such notification level within one year of such declaration. Such declaration shall clearly state where and the date by which such testing must occur. After the commissioner promulgates regulations adding such emerging contaminant, such regulations shall

supersede the declaration issued pursuant to this subdivision. Until such notification levels are posted on the department's website pursuant to subdivision six of this section, the commissioner shall post the notification levels established by declaration on such website so that they are easily accessible through a link to the public.

8. Whenever one or more emerging contaminants is confirmed to be present in drinking water at concentrations at or above a notification level established pursuant to this section:

a. the covered public water system shall notify the department within twenty-four hours;

b. the covered public water system shall notify all owners of real property served by the covered public water system in a time and manner to be prescribed by the department, provided that in no event shall notification occur more than ninety days after the presence of an emerging contaminant at concentrations at or above a notification level established pursuant to this section is confirmed;

c. the commissioner may directly notify such owners of real property if it is determined that the public's interest would be best served by such notification, or if the commissioner determines that the covered public water system is not acting, or cannot act in a timely manner;

d. the commissioner may require that the covered public water system take such actions as may be appropriate to reduce exposure to emerging contaminants. If the commissioner determines that the concentration of the emerging contaminant constitutes an actual or potential threat to public health, based on the best available scientific information, the commissioner shall consult with the commissioner of the department of environmental conservation regarding any further action that may be appropriate, including but not limited to actions pursuant to title twelve of article twenty-seven of the environmental conservation law.

9. The commissioner shall work in consultation with the commissioner of the department of environmental conservation to develop educational

materials, and may take into consideration recommendations of the drinking water quality council established pursuant to section eleven hundred thirteen of this title. Such educational materials shall be made available through a link on the department's website that is easily accessible to the covered public water system and the general public, relating to methodologies for reducing exposure to emerging contaminants and potential actions that may be taken to mitigate or remediate emerging contaminants. Such link shall also include information relating to notification levels established by declaration pursuant to subdivision seven of this section and by regulation pursuant to subdivision six of this section. The commissioner shall coordinate with the United States Environmental Protection Agency to ensure that the information available on the EPA's Drinking Water Watch website is available to public water systems and that information available on the EPA's Safe Drinking Water Information System is available to the public through an easily accessible link on the department's website. The website and such links shall allow, to the extent practicable, the public to easily access information including but not limited to, basic water system information, including system identification number, name and type, department contacts, public notices, violations and enforcement actions taken by the state and federal government. The website and such links shall be monitored and updated regularly by the department. The commissioner shall also provide the covered public water system with information relating to potential funding sources provided by the state and federal government for mitigation or remedial activities, and to reduce the exposure to emerging contaminants.

10. Any owner of real property, including any owner's agent, to whom a covered public water system has provided notification of the exceedance of a notification level established pursuant to subdivision six of this section, shall take all reasonable and necessary steps to provide, within ten days, any tenants with copies of the notification provided by the covered public water system.

11. The commissioner may promulgate regulations pursuant to which the department may provide financial assistance for compliance with the testing requirements of this section, to any covered public water system

upon a showing that the costs associated with testing drinking water in compliance with this section would impose a financial hardship. Such regulations shall, when prioritizing public water systems for eligibility for financial assistance, incorporate provisions that give preference to public water systems serving less than ten thousand individuals.

12. The commissioner shall periodically review substances that have been identified as emerging contaminants pursuant to this section and determine if the department should establish a maximum contaminant level for the substance. Such review shall occur, at a minimum, once every three years.

13. The commissioner shall make draft regulations containing the first list of emerging contaminants within one hundred eighty days of the effective date of this subdivision and shall make regulations implementing this subdivision within ninety days thereafter.

14. The commissioner shall make regulations updating the list of emerging contaminants and their associated notification levels to reflect the latest available scientific information at least once every three years. The commissioner shall add new emerging contaminants under subdivision three of this section at least once every three years.

§ 1113. Drinking water quality council; established. 1. There shall be established, within the department, the drinking water quality council. Such council shall be composed of twelve members as follows:

(a) the commissioner, or the commissioner's designee, who shall be the chair of the council;

(b) the commissioner of environmental conservation or designee;

(c) a designee of the commissioner of environmental conservation with expertise in water resources;

(d) a designee of the commissioner with expertise in drinking water; and

(e) eight members appointed by the governor, two of whom shall be recommended by the temporary president of the senate, and two by the

speaker of the assembly.

2. (a) Of the four members appointed to the drinking water quality council and recommended by the temporary president of the senate and the speaker of the assembly, the temporary president of the senate and the speaker of the assembly shall each recommend:

- (i) one member who represents water purveyors; and
- (ii) one member representing the public, who has a background or expertise in toxicology or health risk assessment.

(b) Of the four additional members appointed to the drinking water quality council, the governor shall appoint:

- (i) one member who represents water purveyors;
- (ii) one member who has a background or expertise in toxicology or health risk assessment;
- (iii) one member who has a background or expertise in microbiology; and
- (iv) one member who has a background or expertise in environmental engineering.

(c) The members of such council appointed pursuant to paragraph (e) of subdivision one of this section shall serve terms of two years.

(d) The members appointed pursuant to paragraph (e) of subdivision one of this section shall each serve his or her term of office or until his or her successor is appointed; provided that any vacancy in the position of an appointed member shall be filled in the same manner as the original appointment and only for the unexpired term of the vacancy.

3. The members of the drinking water quality council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties pursuant to this title.

4. The drinking water quality council shall meet at such times and places as may be determined by its chair. The council shall meet at a minimum of two times per year. All meetings shall be open to the public pursuant to article seven of the public officers law. A majority of the members of such council shall constitute a quorum for the transaction of business. Action may be taken, and motions and resolutions adopted, at

any meeting by the affirmative vote of a majority of the full membership of the council.

5. The council shall make recommendations to the department relating to:

(a) those contaminants, which the department may list as emerging contaminants pursuant to section one thousand one hundred twelve of this title.

(i) In determining what substances shall be recommended as emerging contaminants the council shall, at a minimum, consider:

A. unregulated contaminants monitored pursuant to the federal Safe Drinking Water Act (42 USC § 300g-1) as amended from time to time;

B. substances that require regulation or monitoring when present in drinking water in other jurisdictions outside the state of New York;

C. pesticide chemicals for which the United States environmental protection agency has set human health benchmarks for drinking water;

D. substances found at sites in remedial programs located inside and outside the state of New York, including but not limited to inactive hazardous waste sites; and

E. waterborne pathogens and microbiological contaminants.

(ii) The council shall recommend a notification level for each recommended emerging contaminant.

(iii) The council shall recommend timeframes and frequencies in which testing should be required for the recommended emerging contaminants, allowing for variation based on circumstances such as the source of water, the region and size of the water system.

(iv) The council shall provide the department with its first list of recommended emerging contaminants and corresponding notification levels for which testing shall be required no later than one year from the initial meeting of the council, and the council shall update the list and recommend notification levels annually thereafter;

(b) a review of substances identified as emerging contaminants

pursuant to section one thousand one hundred twelve of this title. Where appropriate the council shall recommend either a maximum contaminant level (MCL), or the removal of the substance from the list of emerging contaminants, on the basis of available scientific evidence and any other relevant factors;

(c) the form and content of public notifications issued pursuant to section one thousand one hundred twelve of this title;

(d) working with other state agencies and the federal government to ensure funds are available and accessible, parties known to be responsible for contamination are pursued, and mitigation, remediation, and cleanup projects occur in a timely manner;

(e) the development of educational materials regarding private well water testing;

(f) the appropriate use of, and methods and manner of conducting, biomonitoring and biomonitoring studies;

(g) the inclusion of information on the online tracking and mapping system established in section 3-0315 of the environmental conservation law; and

(h) anything else the department or the department of environmental conservation designates.

6. The drinking water quality council shall be entitled to request and receive information from any state, municipal department, board, commission or agency that may be required or are deemed necessary for the purposes of such council, including but not limited to all water information and annual reports the department has relating to both public and private water supplies.

7. Before the council advances any recommendation to the department, the council shall provide an opportunity for public and stakeholder comments. Final recommendations of the council shall be posted on the department's website within thirty days after the council adopts such recommendations.

§ 1114. Lead service line replacement grant program. 1. The department shall allocate appropriated funds equitably among regions of the state.

Within each region, the department shall give priority to municipalities that have a high percentage of elevated childhood blood lead levels, based on the most recent available data. In distributing the awards allocated for each region to such priority municipalities, the department shall also consider whether the community is low income and the number of lead service lines in need of replacement. The department may request that such municipalities provide such documentation as the department may require to confirm award eligibility.

2. Further, the department shall establish a statewide plan for lead service line replacement, which shall include, at a minimum, a report on the implementation of subdivision one of this section, resources and techniques for identifying lead service lines throughout the state, the cost of replacing lead service lines, recommendations for municipalities on methods for evaluating the status of lead service lines present and guidance on replacement.

3. The department shall publish information, application forms, procedures and guidelines relating to the program on its website and in a manner that is accessible to the public and all potential award recipients.

§ 1114-a. Voluntary public water system consolidation study. 1. There shall be established in the department, by the commissioner, a voluntary public water system consolidation study designed to evaluate the feasibility of the joining of public water systems in order to improve water quality. Such study shall include:

(a) the feasibility of joining of two or more public water systems to form one water system;

(b) the feasibility of the consolidation of one or more public water systems into a larger public water system;

(c) the appropriate technical, managerial and financial capacity necessary for consolidation, including state funding mechanisms and incentives that could be utilized;

(d) potential public health impacts of consolidation, including ability to meet legally required water quality standards and the impact

on monitoring, reporting and enforcement of drinking water standards;

(e) appropriate and sufficient guidance from the department necessary for those public water systems interested in consolidation; and

(f) recommendations for public water systems interested in voluntary consolidation.

2. The department shall prepare and submit a report and supporting materials to the governor, the temporary president of the senate and the speaker of the assembly setting forth the information gathered and recommendations to the legislature by January first of the following year.

§ 1114-b. Service line inventories and mapping. 1. Definitions. For the purposes of this section:

(a) "Service line" means any piping connecting a water main to a building inlet.

(b) "Gooseneck, pigtail, or connector" means a short section of piping, typically not exceeding two feet, which can be bent and used for connections between rigid portions of a service line, as defined in 40 CFR 141.2.

(c) "Galvanized service line" means iron or steel piping that has been dipped in zinc to prevent corrosion and rusting.

(d) "Covered public water system" means (i) a public water system that serves at least fifteen service connections used by year-round residents or regularly serves at least twenty-five year-round residents; or (ii) a public water system that regularly serves at least twenty-five of the same people, four hours or more per day, for four or more days per week, for twenty-six or more weeks per year.

2. Each covered public water system shall submit a service line inventory, in a format to be developed by the department, that identifies the location, material composition, and other details of all service lines connected to its distribution system. Each covered public water system shall also submit an inventory summary form, in a format to be developed by the department, summarizing the data identified in the service line inventory. Notwithstanding subdivisions three and four of

this section, the development of service line inventories and inventory summary forms shall comply with requirements promulgated by the United States environmental protection agency.

3. Each service line shall be listed in service line inventories. Each covered public water system shall include for each service line the information listed in this subdivision. The covered public water system may mark "unknown" where documented evidence is not currently available:

- (a) street address;
- (b) town;
- (c) zip code;
- (d) if known, whether a gooseneck, pigtail, or connector made of lead is present;
- (e) if known, the material composition of both the public portion and customer portion of the service line;
- (f) if known, whether the public portion or customer portion of the service line was ever made of lead;
- (g) the verification method used to determine the material composition of both the public portion and customer portion of the service line;
- (h) if known, the installation or replacement date of both the public portion and customer portion of the service line;
- (i) if known, the diameter of both the public portion and customer portion of the service line;
- (j) if known, whether lead solder is present;
- (k) if known, the building type; and
- (l) if known, whether a point of use or point of entry treatment system is present.

4. Inventory summary forms shall include, but not be limited to, the following information about each covered water system:

- (a) water system name and identification number;
- (b) contact information for the owner or licensed operator of record completing the form;
- (c) the total number of service lines in the distribution system;
- (d) the total number of lead service lines, including the total number of lead public service line portions and the total number of lead customer service line portions;

(e) the total number of galvanized service lines requiring replacement as defined in 40 CFR 141.84, including the total number of galvanized public service line portions requiring replacement and the total number of galvanized customer service line portions requiring replacement;

(f) the total number of non-lead service lines, including the total number of non-lead public service line portions and the total number of non-lead customer service line portions;

(g) the total number of service lines of unknown material, including the total number of unknown public service line portions and the total number of unknown customer service line portions;

(h) the total number of public service line portions identified by historical records, field inspections, customer identification with photo or other verification, excavation, sequential sampling, statistical analysis/predictive modeling, or other method determined by the covered public water system to accurately identify service line materials;

(i) the total number of customer service portions identified by historical records, field inspections, customer identification with photo or other verification, excavation, sequential sampling, and statistical analysis/predictive modeling, or other method determined by the covered public water system to accurately identify service line materials;

(j) a description of how the service line inventory will be accessible to the public; and

(k) a certification verifying the accuracy of the information.

5. Each covered public water system shall electronically submit to the department an initial service line inventory and an initial inventory summary form no later than October sixteenth, two thousand twenty-four. The department may prescribe data management means and methods for electronic submissions by covered public water systems for uniformity purposes.

6. Covered public water systems whose inventories contain any service lines classified as lead, galvanized requiring replacement as defined in 40 CFR 141.84, or unknown shall electronically submit updated service line inventories and inventory summary forms to the department at least

annually. Updated service line inventories and inventory summary forms shall reflect information gathered during any service line replacements or service line material inspections that may have been conducted. Updated inventory summary forms shall additionally include:

- (a) a description detailing the steps being taken to determine the material composition of unknown service lines;
- (b) the total number of service lines classified as lead, galvanized requiring replacement, or unknown that were replaced over the course of the previous year; and
- (c) the total number of service lines classified as unknown that were determined to be lead, galvanized requiring replacement, or other material over the course of the previous year.

7. Each covered public water system which operates its own website shall make its most recent service line inventory and inventory summary form available to the public on its website.

8. No later than one hundred twenty days after receiving initial and updated service line inventories and inventory summary forms, the department shall make such inventories and inventory summary forms available to the public through the department's website. Each local health department shall include a link on its website to the website maintained by the department for hosting service line inventories and inventory summary forms.

9. No later than October sixteenth, two thousand twenty-six, the department shall make the information from the service line inventories of covered public water systems serving more than ten thousand people and fewer than two million people available to the public on the department's website in the form of an interactive map or maps. Such interactive map or maps shall include, for each service line:

- (a) material classification, including the material classification of both the public and customer portions of a service line;
- (b) street address; and
- (c) the verification method for the service line classification.

10. The department's interactive map or maps shall be searchable by

address, and color-coded where applicable to designate material classification. The department's interactive map or maps shall be updated at least annually, in conjunction with the submission of updated service line inventories by covered public water systems. The department may choose not to create an interactive map when a covered public water system certifies that it maintains and updates its own interactive map, and shall include a link to such interactive map on the department's website.

11. The department shall adopt such rules and regulations as it deems necessary and proper to implement the provisions of this section.

TITLE II

REALTY SUBDIVISIONS: WATER SUPPLY

Section 1115. Realty subdivisions; definitions.

1115-a. Remedy for purchaser of one parcel of unapproved realty subdivision.

1116. Realty subdivisions; plans required to be filed and approved.

1117. Realty subdivisions; duty of county clerk or register in respect to filing of plans and map.

1118. Realty subdivisions; local regulations.

1119. Realty subdivisions; filing fees to accompany plans.

1120. Realty subdivisions; regulation by commissioner.

§ 1115. Realty subdivisions; definitions. 1. As used in sections one thousand one hundred fifteen to one thousand one hundred eighteen of this chapter, inclusive, the word "subdivision" shall mean any tract of land which is divided into five or more parcels, after the effective date of this act, along an existing or proposed street(s), highway(s), easement(s) or right(s)-of-way for sale or for rent as residential lots or residential building plots, and in the county of Suffolk also as business, commercial or industrial lots or building plots, regardless of whether the lots or plots to be sold or offered for sale, or leased for any period of time, are described by metes and bounds or by reference to

a map or survey of the property or by any other method of description and regardless of whether the lots or plots are contiguous. A tract of land shall constitute a subdivision upon the sale, rental or offer for sale or lease of the fifth residential lot or residential building plot therefrom within any consecutive three year period, and at this time the provisions of section eleven hundred sixteen of the public health law shall apply to all such parcels thereof, including the first four parcels, regardless of whether said parcels have been sold, rented or offered for sale or lease singly or collectively.

2. The word "tract" shall mean any body of land, including contiguous parcels of land, under one ownership or under common control of any group of persons acting in concert as part of a common scheme or plan.

3. "Residential lot" or "residential building plot" shall mean any parcel of land of five acres or less, any point on the boundary line of which is less than one-half mile from any point on the boundary line of another such lot in the same tract, unless any such lot may not legally be used for residential purposes. Without limiting the generality of the foregoing, the term "residential" shall include temporary, seasonal and permanent residential use.

§ 1115-a. Remedy for purchaser of one parcel of unapproved realty subdivision. 1. The owner of a parcel of land acquired as one parcel for residential purposes may apply to the local or state health department having jurisdiction for a certificate approving the water supply for said parcel as adequate and satisfactory. The application shall include the description of the parcel as specified in the instrument, by which owner acquired title.

2. The proper department shall entertain said application and issue said certificate providing that the water supply shall, in the opinion of such department, be adequate in quality and potable and unobjectionable in physical and chemical quality and not be or become so polluted or subject to such pollution as to constitute a menace or potential menace to the public health or the health of persons using or

who may use the water thereby supplied.

3. The certificate approving the water supply for said parcel shall contain the name of the owner-applicant and the description of the property set forth in the application. The owner shall append the certificate of approval to a verified petition directed to the county clerk of the county wherein the property is located, praying that the petition and certificate of approval annexed be recorded and indexed against the owner-petitioner.

4. The county clerk upon receiving the petition with annexed certificate of approval, and upon tender of the lawful recording fees, shall record the same in his office and index it against the owner-petitioner. The recording of the petition with annexed certificate of approval shall be deemed compliance with section eleven hundred sixteen of this title, for the parcel described.

5. This section shall apply only to a single residential lot which was acquired May third, nineteen hundred sixty-six without having complied with the provisions of former section eighty-nine of the public health law or section eleven hundred sixteen of this title but was:

(a) acquired by the owner-applicant prior to January first, nineteen hundred seventy-one; or

(b) acquired by the owner-applicant through devise or intestate succession; or

(c) not at the time of acquisition of title by the owner-applicant, a part of a subdivision, as such term is defined in section eleven hundred fifteen of this title.

In addition, this section shall apply to a single residential lot which the appropriate department deems proper for approval because of hardship or other special circumstances established to its satisfaction by the owner-applicant.

§ 1116. Realty subdivisions; plans required to be filed and approved.

1. No subdivision or portion thereof shall be sold, offered for sale,

leased or rented by any corporation, company or person, and no permanent building shall be erected thereon, until a plan or map of such subdivision shall be filed with and approved by the department or city, county, or part-county department of health having jurisdiction and in the county of Suffolk until a plan or map shall have been also filed with and approved by the county department of environmental control and such plan or map thereafter filed in the office of the clerk of the county in which such subdivision is located.

2. Such plan or map shall show methods for obtaining and furnishing adequate and satisfactory water supply to said subdivision.

3. The installation of such facilities shall be in accordance with the plans or any revision or revisions thereof approved by the department or city, county or part-county department of health having jurisdiction.

§ 1117. Realty subdivisions; duty of county clerk or register in respect to filing of plans and map. The county clerk or register shall not file nor record nor accept for filing or recording any map or plat showing a subdivision of land in any town, village or city having a population of less than one million unless there is endorsed thereon or annexed thereto a certificate of the department or city, county or part-county department of health having jurisdiction approving the water supply system proposed or installed for such subdivision and consenting to the filing thereof.

§ 1118. Realty subdivisions; local regulations. 1. Any city or county which has established or establishes a city, county or part-county department of health may adopt regulations for the control of such developments. Regulations adopted by a county or city board of health may include, but not be limited to, establishment of such requirements as it may deem necessary to guarantee the installation of such water supply in accordance with the plans heretofore or hereinafter approved by the county or city department of health or any approved revision or revisions thereof.

2. Nothing contained in sections one thousand one hundred fifteen to one thousand one hundred eighteen of this chapter, inclusive, shall be construed to delegate the general powers of the department of environmental conservation nor to impair nor to deprive such department of its powers and functions as now provided by law.

§ 1119. Realty subdivisions; filing fees to accompany plans. 1. At the time of submitting a plan for approval as required by this article, a filing fee computed at the rate of fifty dollars per lot shall be paid to the department or to the city, county or part-county health district wherein such plans are filed.

2. The department, or the city, county or part-county health district, shall not review or approve any such subdivision map submitted for approval after this section takes effect until such fee, as herein provided, has been received by it.

3. If any plan submitted to the department, or to a city, county or part-county health district, cannot be approved, such plan shall be returned to the person who submitted the plan with a summary of the reasons for disapproval.

4. Notwithstanding any other provision of this title the commissioner is empowered to make administrative arrangements with the commissioner of environmental conservation for joint or cooperative administration of this title and title fifteen of article seventeen of the environmental conservation law, such that only one plan must be filed and only one fee totaling one hundred dollars per lot must be paid.

§ 1120. Realty subdivisions; regulation by commissioner. The commissioner of health may from time to time establish by rule or regulation standards for subdivisions necessary to effect the purposes of this title and not inconsistent with regulations of a city, county or part-county department of health having jurisdiction, now or hereafter

adopted pursuant to law. In the event of and to the extent of such inconsistency, the standards established by the commissioner shall be deemed inapplicable.

TITLE II-A

WATER SUPPLY EMERGENCY PLANS

Section 1125. Water supply emergency plans.

§ 1125. Water supply emergency plans. 1. Definitions. As used in this title:

(a) "Water supply emergency plan" shall mean a plan reviewed and approved by the commissioner and filed with the department. The plan shall follow a form which shall be specified by the department and which shall include, but not be limited to, those items enumerated in this section, and shall address those actions to be taken by a water supplier to anticipate emergencies and respond responsibly to emergency situations. The department shall maintain a list of all water suppliers required to submit a water supply emergency plan pursuant to this section.

(b) "Water supplier" shall mean any person who owns or operates a community water system that supplies drinking water to more than three thousand three hundred people.

2. All water suppliers shall prepare a water supply emergency plan; provided, however, if more than one water supplier is responsible for the same system, such plan shall be submitted jointly by such two or more water suppliers. The plan shall identify and outline the steps necessary to ensure that potable water is available during a water supply emergency. The water supply emergency plan shall include, but not be limited to, the following:

(a) establishment of criteria and procedures to determine critical water levels or safe yield of system,

(b) identification of existing and future sources of water under normal conditions and emergency conditions,

(c) system capacity and ability to meet peak demand and fire flows

concurrently,

- (d) storage capacities,
- (e) current condition of present interconnections and identification of additional interconnections to meet a water supply emergency,
- (f) specific action plan to be followed during a water supply emergency including a phased implementation of the plan,
- (g) general water conservation programs and water use reduction strategies for water supply emergencies,
- (h) prioritization of water users,
- (i) identification and availability of emergency equipment needed during a water supply emergency,
- (j) public notification program coordinated with the phased implementation schedule, and
- (k) a vulnerability analysis assessment, including an analysis of vulnerability to terrorist attack and cyber attack, which shall be made after consultation with local and state law enforcement agencies.

3. All water suppliers shall, prior to the final submission of the water supply emergency plan, publish a notice in a newspaper of general circulation in the area served by the community water system stating that the proposed water emergency plan is available for review and comment; provided, however, a water supplier shall exempt from public disclosure for public review and comment any information it determines to pose a security risk to operation of the water supply system. Such notice shall be printed at least once in each of two successive weeks and the water supplier shall accept public comment for at least fourteen days following the date of the first publication. The water supplier shall submit all public comments with the water emergency plan to the department.

4. Water supply emergency plans shall be submitted to the commissioner on or before December thirty-first, nineteen hundred ninety. All water suppliers who have previously submitted emergency water supply plans which were approved by the commissioner prior to the effective date of this title are exempt from the provisions of this subdivision. The commissioner shall retain a copy of each water supply emergency plan.

5. Every water supplier shall review, and if necessary, revise its water supply emergency plan and report its findings to the commissioner by December thirty-first, nineteen hundred ninety-five. Any water supplier whose water supply emergency plan does not include an analysis of vulnerability to terrorist attack and cyber attack, shall initiate such an analysis by June first, two thousand seventeen, and shall revise its emergency plan and report its findings to the commissioner by January first, two thousand eighteen. Every water supplier shall keep its water supply emergency plan up to date, shall provide updated communication and notification information to the commissioner by December thirty-first of every year, and shall submit its water supply emergency plan to the commissioner for review at least once every five years and within thirty days after major water facility infrastructure changes have been made. The commissioner shall make available for review, following established security protocols, a copy of each vulnerability analysis assessment from a water supplier to the superintendent of state police, commissioner of the division of homeland security and emergency services, and chief technology officer.

6. (a) The commissioner or a county health department may provide guidance and assistance to community water systems on conducting vulnerability assessments, preparing water supply emergency plans and addressing threats from terrorist attacks, including cyber attacks, designed to disrupt the provision of safe drinking water or significantly affect the public health, or significantly affect the safety or supply of drinking water provided to communities or individuals.

(b) A community water system, that is not a water supplier, may elect to complete a water supply emergency plan. Such community water system may elect to submit the plan to the commissioner for approval. In such a case, the commissioner shall subject the plan to such approval process as described in paragraph (a) of subdivision one of this section.

7. The commissioner, in his discretion, may provide an opportunity for public hearing for persons served by a community water system.

8. The commissioner shall make such rules and regulations which may be

necessary to effectuate the purposes of this title.

9. The commissioner, superintendent of state police, commissioner of the division of homeland security and emergency services, and chief technology officer shall keep confidential: (a) all vulnerability analysis assessments and all information derived therefrom; and (b) all information determined by a water supplier to pose a security risk to the operation of a water supply system. Such assessments and information shall be exempt from disclosure under article six of the public officers law. A person who, without authorization, discloses any such assessment or information to another person who has not been authorized to receive such assessment or information is guilty of a class A misdemeanor.

TITLE III

ANNUAL WATER SUPPLY STATEMENT

Section 1150. Definitions.

1151. Annual water supply statement.

1152. Annual water supply statement; delivery.

1152-a. New York state public water supply report.

1153. Rules and regulations.

§ 1150. Definitions. As used in this title the term "water works corporation" shall mean any entity that has one thousand or more water service connections, and comes within the definition in section two of the public service law or paragraph (a) of subdivision one of section one hundred twenty-u of the general municipal law.

§ 1151. Annual water supply statement. Each water works corporation shall prepare and provide an annual water supply statement to the customers it serves. Such statement shall contain such information as is required in this title as well as any additional information required by the commissioner. Additionally, the statement shall provide a section which explains, in plain language, the information required in the statement. The department may prepare or prescribe a format or model

upon which all such statements shall be produced. The annual water supply statement shall include, but not be limited to, the following items of information:

1. A brief description on the source or sources of the water supply and the general qualitative and quantitative condition of the water source.
2. The population served.
3. For water works corporations that calculate water use of all customers with meters, an accounting of the total annual amount of water withdrawn, delivered, and lost from the system.
4. The analytical testing results for those constituents required to be tested for under part five of the state sanitary code or as required by appropriate local health units, except for microbiological results, for each source of water.

Where more than one analysis per year is conducted on a specific constituent, the water works corporation shall list the range of results from highest to lowest during the reporting period. The applicable state guideline, standard, or MCL for each constituent present shall be listed and any instance where a state guideline, standard, or MCL is violated shall be noted.

For microbiological analyses as required by part five of the state sanitary code, the water works corporation shall indicate any instance where the water supply violated the MCL. The date or dates of violation, the location where the violation occurred, and the response of the water works corporation shall be listed.

5. A brief description of the types of treatment that the water receives before entering the distribution system.

6. Any water sources restricted, removed from service, or otherwise limited in their use and any actions taken to secure new supplies or

replace lost capacity. For the purposes of this subdivision, "water sources" shall include surface water sources, such as, but not limited to, lakes, ponds, rivers, streams, reservoirs and impoundments and for groundwater sources, supply wells. For the purposes of this subdivision, "water sources" shall not include water mains or other types of conveyance infrastructure.

7. Information on water conservation measures customers can implement such as, but not limited to, retrofitting plumbing fixtures, altering irrigation timing, using irrigation sensors, leak detection, proper use of water-conserving appliances, daily conscientious use of water, and the estimated savings in water and energy or money from the use of such measures.

8. A description of the risks associated with exposure to cryptosporidium parvum or giardia lamblia for specific at-risk populations and the general public and measures that at-risk populations can take to protect themselves according to recommendations by the department or other governmental public health or environmental agencies. In addition, for water works corporations that test for cryptosporidium parvum or giardia lamblia, a summary of the following: sampling sites; number of tests per year; testing results and actions taken in response to those results.

9. General information regarding lead pipes reasonably known to be located within the water system, as that term is defined in subdivision twenty-six of section two of the public service law.

The commissioner may add such additional requirements as he determines to be appropriate.

§ 1152. Annual water supply statement; delivery. 1. Each water works corporation shall provide a water supply statement to its customers annually. The annual water supply statement shall either be mailed to each customer or published in at least one newspaper of general circulation in the area served by the water works corporation. If the

statement is to be published in a newspaper, the water works corporation shall provide ample notification by announcing the publication date and newspaper name either on the customers bill or in the newspaper in which the statement shall appear. A limited number of additional copies, in a quantity to be determined by the water works corporation, shall be provided to customers upon request. In addition, the statement must be posted on the water works corporation's website, if such exists, or be made available to the municipality or municipalities in which the water works corporation services to be posted on such municipalities' website, if such exists.

2. Each water works corporation shall also provide one copy of each annual water supply statement to the commissioner and the state commissioner of environmental conservation.

3. The annual water supply statement shall be mailed or published, and posted online on or before the thirty-first day of May of each year and shall apply to data received by the water works corporation during the preceding calendar year.

4. The information required by subdivision four of section eleven hundred fifty-one of this title for each source of water may be placed in a supplement to the annual water supply statement instead of in the main body of the statement; provided that:

(1) the statement provides such information for a representative sampling of distribution point samples and a notice to the effect that such information for each source of water is included in a supplement available to each customer upon request from the water works corporation; and

(2) the supplement is included in each copy of the water supply statement provided to customers upon request under subdivision one of this section and provided to commissioners under subdivision two of this section; and

(3) the supplement shall be

(i) published in a notice at least one-half page in size, in one newspaper of general circulation within the water district; or

(ii) made available on a public electronic bulletin board, along with

the supplements from the two prior years, if such prior supplements exist, and notice of the availability of such information on a public electronic bulletin board shall be clearly provided on each billing statement and shall be published in a newspaper of general circulation within the water district; or

(iii) made available at all New York state documents information access centers, documents reference centers, documents depository libraries and documents research depository libraries within the water district and if no such libraries exist within the water district, at a public library within the water district, and notice of the availability of the supplement at such library of libraries shall be clearly provided on each billing statement and shall be published in a newspaper of general circulation within the water district.

Such supplement need not be included in the copy of the annual water supply statement mailed to each customer or published under subdivision one of this section.

§ 1152-a. New York state public water supply report. The department, shall prepare an annual New York state public water supply report. Such report shall consist of a compilation and analysis of the information and data submitted by water suppliers pursuant to the provisions of this article.

§ 1153. Rules and regulations. The department shall have the power to make any rules and regulations that are necessary and appropriate to carrying out the purposes of this title.

TITLE IV

DRINKING WATER REVOLVING FUND

Section 1160. Definitions.

1161. Eligible projects; priority ranking.

1162. Financial assistance; criteria and standards;
regulations.

1163. Financing agreements.

- 1164. Inspection and certification.
- 1165. Noncompliance; notification.
- 1166. Implementation agreements.
- 1167. Financial assistance; recipients.
- 1167-a. Reimbursement of state assistance payments or grants made to municipality or recipient; admissibility of state assistance payments or grants as collateral source.
- 1168. Construction contracts; designations.
- 1169. Compliance with other laws.

§ 1160. Definitions. As used in this section:

1. "Allocation" means the amount of moneys allocated to reduce a recipient's or group of recipients' total financing costs for one or more eligible projects.

2. "Construction" means the erection, building, acquisition, alteration, reconstruction, improvement, enlargement or extension of an eligible project; the inspection and supervision thereof; and the engineering, architectural, legal, fiscal, and economic investigations and studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

3. "Corporation" means the New York state environmental facilities corporation, continued pursuant to section twelve hundred eighty-two of the public authorities law, or any successor thereto.

4. "Eligible project" means a project for construction of a water supply facility which is intended to improve drinking water facilities, including a project that would be eligible for financing under or designed to comply with the requirements of the federal safe drinking water act or other applicable federal law and state drinking water quality goals and standards, which the commissioner has determined:

(a) is necessary for the objectives and goals of the state sanitary code or the federal safe drinking water act to assure safe public

drinking water;

(b) represents a reasonable effort to develop a viable water supply that can consistently meet drinking water standards;

(c) takes into consideration the water resources management strategy pursuant to title twenty-nine of article fifteen of the environmental conservation law;

(d) is a project for which financial assistance is available from the fund; and

(e) conforms with applicable state rules and regulations.

5. "Financial assistance to a recipient" has the same meaning as set forth in subdivision four of section twelve hundred eighty-five-m of the public authorities law.

6. "Financing agreement" means an agreement between the corporation and one or more recipients meeting the requirements of section eleven hundred sixty-three of this title.

7. "Fund" means the drinking water revolving fund established under section twelve hundred eighty-five-m of the public authorities law.

8. "Intended use plan" means a plan identifying the intended uses of the amounts available in the fund, including but not limited to:

(a) a list of those projects for construction of water supply facilities on the priority list developed pursuant to section eleven hundred sixty-one of this title;

(b) a description of the short and long term goals and objectives of the fund;

(c) information on the activities to be supported, including a description of project categories, terms of financial assistance and communities served; and

(d) the criteria and method established for the distribution of financial assistance from the fund.

9. "Municipality" means any county, city, town, village, district corporation, county or town improvement district, school district, Indian nation or tribe recognized by the state or the United States with

a reservation wholly or partly within the boundaries of New York state, any public benefit corporation or public authority established pursuant to the laws of New York or any agency of New York state which is empowered to construct and operate an eligible project, or any two or more of the foregoing which are acting jointly in connection with an eligible project.

10. "Recipient" means any municipality, public utility, or person, including any individual, firm, partnership, association, not-for-profit corporation or other corporation organized and existing under the laws of the state or any other state which is empowered to construct and operate an eligible project, or any two or more of the foregoing which are acting jointly in connection with an eligible project.

§ 1161. Eligible projects; priority ranking. Subject to the provisions of section thirty-two of the chapter of the laws of 1996 which added this section, in consultation with the commissioner of environmental conservation, the commissioner shall establish and maintain a list of potentially eligible projects and shall establish, pursuant to rules and regulations, a process for listing potentially eligible projects identified by potential recipients and a priority ranking system for the purpose of providing financial assistance to recipients for such projects under this title. In establishing such system, the commissioner shall take into account the public health significance of such potentially eligible projects which shall include, but need not be limited to, an assessment of (i) public health and safety; (ii) population affected; (iii) attainment of state drinking water quality goals and standards; (iv) taking into consideration the water resources management strategy pursuant to title twenty-nine of article fifteen of the environmental conservation law; (v) taking into consideration future physical climate risk due to sea level rise, and/or storm surges and/or flooding, based on available data predicting the likelihood of future extreme weather events, including hazard risk analysis data if applicable; and (vi) compliance with state and federal law, rules and regulations.

§ 1162. Financial assistance; criteria and standards; regulations. 1.

The corporation is authorized to promulgate regulations, developed in consultation with the commissioner and the director of the division of the budget, for the purpose of carrying out its responsibilities under this title, including establishing criteria and standards for determining the amount and kind of financial assistance to a recipient for an eligible project. To the extent financial assistance to a recipient for an eligible project is provided from the proceeds of bonds or notes of the corporation, the amount of an allocation applicable to the portion of such eligible project financed with such financial assistance shall be determined by the corporation in accordance with such regulations, if any.

2. The department is authorized to promulgate regulations, developed in consultation with the director of the division of the budget and the corporation, for the purpose of carrying out its responsibilities under this title.

§ 1163. Financing agreements. The corporation and any recipient having the power to contract with respect to the financing of an eligible project may enter into a loan or other financing agreement providing for the construction and financing of eligible projects. The corporation shall prepare each financing agreement, which shall include but is not limited to the following provisions:

1. A description of the eligible project;
2. An estimate of the eligible project cost;
3. A right of the corporation to approve any contracts for services and construction funded pursuant to a financing agreement, and to inspect and review the construction of eligible projects;
4. Notwithstanding the provisions of any other law, general, special or local, inconsistent with this section, a right of the corporation to

invest proceeds of the corporation's bonds or notes, including proceeds of bonds or notes of the recipient, as provided in subdivision four of section twelve hundred eighty-four of the public authorities law and as provided in subdivision six of section twelve hundred eighty-five-m of the public authorities law.

Such right shall include the right to invest such monies together with any other monies held by the corporation pursuant to the provisions of section twelve hundred eighty-five-m of the public authorities law;

5. Remedies in the event of a recipient's failure to comply with the terms of a financing agreement;

6. An agreement by the corporation to:

(a) lend to the recipient for the construction of an eligible project a specified amount from the proceeds of the corporation's bonds or notes, not to exceed the estimated reasonable cost of construction of the eligible project established in the financing agreement, subject to the ability of the corporation to provide such financing, including any other approvals required by state or federal law and such other conditions as the corporation shall determine necessary or desirable;

(b) use reasonable efforts to issue its bonds or notes in an amount sufficient to finance the estimated reasonable cost of the eligible project, including but not limited to costs of issuance, credit support fees, if any, trustees' fees, interest during construction, and such reserve funds, if any, as may be necessary to secure such bonds or notes;

(c) for any financial assistance made from the proceeds of the corporation's bonds or notes, establish an allocation and provide to the recipient an interest rate subsidy allocation for the eligible project in accordance with this title and section twelve hundred eighty-five-m of the public authorities law;

(d) in the alternative, provide financial assistance to the recipient for the construction of an eligible project in a specified amount from any moneys in or available for deposit in the fund, not to exceed the estimated reasonable cost of construction of the eligible project established in the loan or other financing agreement, as determined by

the corporation;

(e) administer the investment of funds held in accordance with such agreement, including funds of the recipient;

7. An agreement by the recipient to:

(a) proceed expeditiously with and complete the eligible project in accordance with plans approved;

(b) commence operation of the eligible project on completion of the project, and not abandon, discontinue operation of, sell, transfer or otherwise dispose of the eligible project as long as a loan or other financial assistance to the recipient for such project remains outstanding, without approval of the commissioner; provided, however, that the commissioner shall not approve disposition of the eligible project without the concurrent approval of the corporation. None of the foregoing shall limit the commissioner's authority to terminate or impose conditions upon the operation of an eligible project pursuant to the provisions of this chapter and any implementing regulations thereto;

(c) operate and maintain the eligible project in accordance with applicable requirements of federal and state law;

(d) establish and maintain project accounts in accordance with the financing agreement and generally accepted accounting standards;

(e) establish a dedicated source of revenue (which may include a general obligation of the recipient) providing for:

(i) operation and maintenance costs of the eligible project and equipment renewal and replacement; and

(ii) loan repayment regardless of whether the eligible project is in operation;

(f) notwithstanding the provisions of any other law, general, special or local, inconsistent with this section, delegate to the corporation the authority to invest proceeds of bonds or notes issued by the corporation or the recipient on behalf of the recipient; and

(g) permit any reviews or audits and provide assistance determined to be reasonable and necessary by the department or the corporation;

8. Such other agreements or covenants as may be deemed necessary or desirable in connection with the issuance by the corporation of its bonds or notes.

§ 1164. Inspection and certification. The corporation shall provide the means of ensuring compliance by recipients with each financing agreement by:

1. Retaining the right to inspect and review work on each eligible project in progress and upon completion, and determining whether such work was undertaken and completed in compliance with all relevant plans and the terms of such financing agreement;

2. Retaining the right to disburse or refuse to disburse payments to a recipient pursuant to a financing agreement;

3. Retaining the right to disburse or refuse to disburse payments to a recipient pursuant to a financing agreement based upon the determinations of any review or audit;

4. Establishing remedies if work on an eligible project has not been completed in accordance with all relevant plans and the terms of such financing agreement due to factors within the recipient's control; and

5. Requiring a recipient to maintain project accounts with respect to any eligible project.

Nothing herein shall be construed to affect or diminish the general authority of the department to inspect and review the work on any project financed pursuant to this title, or to inspect the records relating to such project, for the purpose of determining compliance with any other provisions of this chapter.

§ 1165. Noncompliance; notification. In the event the work completed pursuant to a financing agreement or loan agreement is deemed not in compliance with such agreement, the corporation shall expeditiously notify the recipient of such non-compliance and indicate the reasons for such determination.

§ 1166. Implementation agreements. For the purpose of implementing the drinking water revolving fund program set forth in this title and section twelve hundred eighty-five-m of the public authorities law, and ensuring compliance with the requirements of the state sanitary code, the federal safe drinking water act or other applicable federal law, the department may:

1. Arrange in consultation with the corporation for independently conducted reviews and audits on at least an annual basis necessary to carry out the objectives of the fund.

2. Submit a copy of each draft intended use plan to the governor, the director of the division of the budget, the chairman of the senate finance committee and the chairman of the assembly ways and means committee and submit a copy of each final intended use plan to such persons.

3. Enter into any agreement between the state of New York and the administrator of the United States environmental protection agency and take all other actions necessary to comply with the requirements of the federal safe drinking water act or applicable federal law and state law, including, but not limited to, approving each project as an eligible project under the program.

4. Enter into such agreements with the corporation as to the administration and implementation of the drinking water revolving fund as may be deemed desirable or necessary, which agreements may provide for among other things, the allocation and delegation of responsibilities of the commissioner, the department or the corporation set forth in this title amongst such parties.

§ 1167. Financial assistance; recipients. The corporation may provide financial assistance to recipients pursuant to paragraph (a) of subdivision four of section twelve hundred eighty-five-m of the public

authorities law from any available moneys in the fund other than the proceeds of the corporation's bonds or notes or moneys needed to comply with subdivision five of section twelve hundred eighty-five-m of the public authorities law if and to the extent the corporation determines that it is unable to, or that it is impractical or inadvisable to, finance all or a portion of the costs of an eligible project from the proceeds of bonds or notes that are special obligations of the corporation.

The interest rate charged on any loan made by the corporation pursuant to this section shall be such interest rate as determined by the corporation (including a zero percent rate of interest), but shall in any event be no more than two-thirds of the market rate of interest otherwise applicable thereto.

§ 1167-a. Reimbursement of state assistance payments or grants made to municipality or recipient; admissibility of state assistance payments or grants as collateral source. 1. A municipality or recipient that: (a) receives a state assistance payment/grant from the corporation for an eligible project to remove contaminants from drinking water or water supplies under this title, including but not limited to state assistance payments/grants for removing emerging contaminants; (b) takes legal action against a responsible party to recover the costs of such eligible project; and (c) receives payment by judgment, settlement or otherwise from such responsible party for the costs for such eligible project, shall reimburse the corporation the portion of such payment that is in excess of (1) the total cost of the project (including, but not limited to, the capital costs and operating and maintenance costs associated therewith for the period during which the contamination is expected to persist and require treatment); and (2) the expenses (including, but not limited to, attorneys' fees and litigation costs and expenses) incurred by the municipality or recipient pursuing recovery of such costs from responsible parties, provided, however, that the municipality or recipient shall not reimburse more than the amount of such state assistance payment/grant for the eligible project.

2. Notwithstanding any other provision of law, including section forty-five hundred forty-five of the civil practice law and rules, evidence of any state assistance payment/grant from the corporation to any municipality or recipient shall not be admissible in any action brought by such municipality or recipient against a responsible party to recover the costs for an eligible project and/or the operating and maintenance costs associated therewith, and the court shall not reduce the amount of any award against a responsible party in whole or in part because of such state assistance payment or grant.

§ 1168. Construction contracts; designations. The contracts for the construction of eligible projects constructed and financed pursuant to a financing agreement shall be subject to the requirements and provisions of article fifteen-A of the executive law and, for such purposes, any such contract shall be considered a "state contract" and the department shall be the "contracting agency" for each such contract.

§ 1169. Compliance with other laws. Nothing contained in this title shall be held to alter or abridge the powers and duties of the department of environmental conservation.

ARTICLE 13

NUISANCES AND SANITATION

Title	I.	General provisions; control and abatement (§§1300-1310).
	II.	Noxious weeds and growths (§§1320-1321).
	III.	Tenement house sanitation (§1325).
	IV.	Labor camp sanitation (§1330).
	V.	Suppression of certain businesses (§§1335-1336).
	VI.	Bathing establishments (§§1340-1342).
	VII.	Hotel sanitation (§§1345-1348).
	VIII.	Food handling (§§1350-1357).
	IX.	Location and disposition of radioactive gold jewelry (§1360).
	X.	Control of lead poisoning (§§1370-1377).

- XI. State aid: planning for construction of solid waste management facilities (§§1380-1383).
- XI-A. New York State Toxic Mold Task Force (§1384).
- XII. Toxic substances (§§1385-1389).
- XII-A. Inactive hazardous waste disposal sites (§§1389-a--1389-e).
- XIII. Storage, treatment and disposal of regulated medical waste (§§1389-aa--1389-gg).

TITLE I

GENERAL PROVISIONS; CONTROL AND ABATEMENT

- Section 1300. Nuisances; general powers of commissioner.
- 1300-a. Putting noisome or unwholesome substances or maintaining noisome business on or near highway.
 - 1300-b. Throwing gas tar or refuse into public waters.
 - 1300-c. Farming activities.
 - 1301. Nuisances; examination and abatement by order of governor; expenses.
 - 1302. Nuisances; local boards of health; duty to assist commissioner.
 - 1303. Nuisances; local boards of health; general powers and duties.
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 - 1311. Hand washing facilities at certain public establishments featuring animals.

§ 1300. Nuisances; general powers of commissioner. 1. The

commissioner shall have all necessary powers to make investigations and examinations into nuisances, or questions affecting the security of life and health in any locality.

2. The commissioner may from time to time employ competent persons to render sanitary service, and make or supervise practical and scientific investigations and examinations requiring expert skill, and prepare plans and reports relative thereto.

§ 1300-a. Putting noisome or unwholesome substances or maintaining noisome business on or near highway. A person, who deposits, leaves or keeps, on or near a highway or route of public travel, either on the land or on the water, any noisome or unwholesome substance, or establishes, maintains or carries on, upon or near a public highway or route of public travel, either on the land or on the water, any business, trade or manufacture which is noisome or detrimental to public health, is guilty of a misdemeanor, punishable by a fine of not less than one hundred dollars, or by imprisonment not less than three nor more than six months, or both.

§ 1300-b. Throwing gas tar or refuse into public waters. A person, who throws or deposits gas tar, or the refuse of a gas house or gas factory, or offal, refuse, or any other noxious, offensive, or poisonous substance into any public waters, or into any sewer or stream running or entering into such public waters, is guilty of a misdemeanor.

§ 1300-c. Farming activities. Notwithstanding any other provision of law, the agricultural activities conducted on a farm, as defined in section six hundred seventy-one of the labor law, shall not be considered a private nuisance, provided such agricultural activities were commenced prior to the surrounding activities, have not increased substantially in magnitude or intensity and have not been determined to be the cause of conditions dangerous to life or health as determined by the commissioner, the local health officer or local board of health

pursuant to sections thirteen hundred, thirteen hundred-a, thirteen hundred three and thirteen hundred four of this chapter.

§ 1301. Nuisances; examination and abatement by order of governor; expenses. 1. Whenever required by the governor, the commissioner shall make an examination concerning nuisances or questions affecting the security of life and health in any locality, and shall report the results thereof to the governor, within the time prescribed by him therefor.

2. The report of every such examination, when approved by the governor, shall be filed in the office of the secretary of state, and the governor may declare the matters public nuisances, which may be found and certified in any such report to be nuisances, and may order them to be changed, abated or removed as he may direct.

3. Every such order shall be presumptive evidence of the existence of such nuisance; and the governor may, by a precept under his hand and official seal, require the district attorney, sheriff and other officers of the county where such nuisance is maintained, to take all necessary measures to execute such order and cause it to be obeyed, and the acts of any such county officer in the abatement of any such nuisance, reasonable or necessary for such abatement, shall be lawful and justifiable and the order of the governor a sufficient protection to such officer.

4. The expense of such abatement shall be paid by the municipality where the nuisance occurs, and shall be a debt recoverable by such municipality of all persons, maintaining it or assisting in its maintenance, and a lien and charge upon the lands upon which the nuisance is maintained, which may be enforced by a sale of such lands to satisfy the same.

§ 1302. Nuisances; local boards of health; duty to assist commissioner. 1. Whenever requested by the commissioner, the board of

health of any health district may appoint one of its members to act with and assist the commissioner during the investigation or examination of any nuisance, or for the purpose of determining whether a public nuisance exists.

2. Such representative may take part in such examination, but the final determination of the questions involved shall rest solely with the commissioner.

§ 1303. Nuisances; local boards of health; general powers and duties.

1. Every local board of health and local health officer shall receive and examine into all complaints made by any inhabitant concerning nuisances, or causes of danger or injury to life and health within the health district, and may enter upon or within any place or premises where nuisances or conditions dangerous to life and health or which are the cause of nuisances existing elsewhere are known or believed to exist, and by its members or other persons designated for that purpose, inspect and examine the same.

2. The local board of health or local health officer having the powers of a local board of health shall furnish the owners, agents and occupants of the premises with a written statement of the results and conclusions of any examination conducted pursuant to the provisions of sections one thousand three hundred three to one thousand three hundred five, inclusive, of this chapter.

3. Every local board of health shall order the suppression and removal of all nuisances and conditions detrimental to life and health found to exist within the health district.

4. Whenever the commissioner shall by notice to the presiding officer of any local board of health, direct him to convene such local board to take certain definite proceedings concerning which the commissioner shall be satisfied that the action recommended by him is necessary for the public good, and is within the jurisdiction of such board of health, such presiding officer shall convene such local board of health, which

shall take the action directed.

§ 1304. Nuisances; local health officers; general powers. The local health officer of a health district having no local board of health and each county health commissioner shall have authority equal to a local board of health to investigate and abate public nuisances which may affect health.

§ 1305. Nuisances; abatement by local boards of health. 1. The owners, agents and occupants of any premises shall permit sanitary examinations and inspections to be made pursuant to the provisions of this article.

2. If the owner or occupant of any premises whereon any nuisance or condition deemed to be detrimental to the public health exists or the cause of the existence elsewhere, fails to comply with any order or regulation of any local board or health officer having the power of a local board of health for the suppression and removal of any such nuisance or other matter, in the judgment of the board or health officer detrimental to the public health, made, served or posted as required in this article, such board or its agents or employees may enter upon the premises to which such order or regulation relates, and suppress or remove such nuisance or other matter.

§ 1306. Nuisances; abatement expenses. 1. The expense of suppression or removal of a nuisance or conditions detrimental to health shall be paid by the owner or occupant of the premises, or by the person who caused or maintained such nuisance or other matters, and the board of health of the municipality or county wherein the premises are located may maintain an action in the name of the municipality or county to recover such expense, and the same when recovered shall be paid to the treasurer of the municipality or county, or if it has no treasurer to its chief fiscal officer, to be held and used as the funds of the municipality or county.

2. Whenever the suppression or removal of such nuisance or conditions detrimental to health demand the immediate expenditure of money, every local board of health, local health officer of a health district having no board of health or county health commissioner shall be authorized to use for such purpose any money in the hands of the board, or may call on the governing body of the municipality or county as the case may be for such money. All such moneys so expended shall be immediately repaid to the fund or source whence they were received on the recovery of the same by action or otherwise from the persons responsible for the expenses of suppression or removal.

§ 1307. Nuisances; abatement expenses; lien and execution. 1. If execution upon a judgment for the recovery of the expense of the suppression or removal of a nuisance or other matter, pursuant to an order or regulation of any local board of health is returned wholly or in part unsatisfied, such judgment, if docketed in the place and manner required by law to make a judgment of a court of record a lien upon real property, shall be a first lien upon such premises, having preference over all other liens and encumbrances whatever. Notwithstanding the foregoing, such lien shall not have preference over any mortgage or other encumbrance for the benefit of the state of New York or a public benefit corporation thereof.

2. The board may cause such premises to be sold for a term of time for the payment and satisfaction of such lien and the expenses of the sale, provided, however, that where such premises are encumbered by a mortgage or other encumbrance for the benefit of the state of New York or a public benefit corporation thereof, the consent of that entity shall first be obtained.

3. Notice of such sale shall be published for twelve weeks successively, at least once in each week, in a newspaper of the city, village or town, or if no newspaper is published therein, in the newspaper published nearest to such premises. If the owner or occupant of the premises, or his agent, is known, a copy of such notice shall be

served upon him, either personally, at least fourteen days previous to the sale, or by mail at least twenty-eight days prior thereto.

4. The premises shall be sold to the person offering to take them for the shortest time, paying the amount unpaid on such judgment and interest and the expenses of the notice and sale. A certificate of the sale, signed and acknowledged by the president and secretary of the board, shall be made and delivered to the purchaser, and may be recorded as a conveyance of real property, and the purchaser shall thereupon be entitled to the immediate possession of such premises, and, if occupied, may maintain an action or proceeding to recover the possession thereof against the occupant, as against a tenant of real property holding over after the expiration of his term; and the cost of any such action or proceeding, if not paid by the occupant, shall also be a lien upon such premises, having the same preference as the lien of such judgment, and the right of the purchaser to such premises shall be extended for a longer term, which shall bear the same proportion to the original term as the amount of such costs bears to the amount paid by the purchaser on such sale.

5. The term of the purchaser at any such sale shall commence when he shall have acquired possession of the premises sold.

6. At any time within six months after recording such certificate of sale, the owner of the premises or any lessee, mortgagee or incumbrancer, thereof, or of any part of the same, may redeem the premises or any such part from such sale by paying to the purchaser the amount paid by him on the sale, and all cost and expenses incurred by him in any action or proceeding to recover possession with interest at the rate of ten per centum per annum thereon. If redemption is made by the owner, the right of the purchaser shall be extinguished; if by a lessee, the amount paid shall be applied as a payment upon any rent due or which may accrue upon his lease; if by a mortgagee or an incumbrancer, the amount paid shall be added to his mortgage, incumbrance or other lien, or if he have more than one to the oldest, and shall thereafter be a part of such mortgage, lien or incumbrance and enforceable as such.

§ 1308. Powers and duties of local boards of health. It shall be the duty of local boards of health to enforce the public health law, the state sanitary code and local sanitary codes whether promulgated by the county or any of the political subdivisions within said county. A local board of health is hereby authorized to make an ex parte application for a temporary restraining order and upon sufficient proof to satisfy it, the court may grant such an order, where there is a violation within the jurisdiction of the local board of health which requires immediate relief.

§ 1309. City of New York; exceptions. The provisions of sections one thousand three hundred three to one thousand three hundred seven of this chapter, inclusive, shall not apply to the city of New York.

§ 1310. Removal of canine wastes in cities with a population of four hundred thousand or more persons and in the cities of Yonkers and Albany. Notwithstanding any contrary provision of law, rule or regulation, in cities with a population of four hundred thousand or more persons and in the cities of Yonkers and Albany, it shall be the duty of each dog owner or person having possession, custody or control of a dog to remove any feces left by his or her dog on any sidewalk, gutter, street or other public area. Any violation of this section shall constitute a violation punishable by a fine or a civil penalty of not more than two hundred fifty dollars. For the purposes of enforcing the provisions of this section, appearance tickets may be issued by sanitation officers, dog enumerators, or wardens and by any persons authorized to issue tickets for parking violations. Notwithstanding any other provision of law to the contrary, in the city of New York, such appearance tickets may be returnable to the environmental control board which shall have the power to impose the civil penalties herein provided. The provisions of this section shall not apply to a guide dog, hearing dog or service dog accompanying any person with a disability, as defined in subdivision twenty-one of section two hundred ninety-two of

the executive law.

§ 1311. Hand washing facilities at certain public establishments featuring animals. 1. All public establishments including, but not limited to, carnivals, fairs and amusement parks, as such terms are defined in section eight hundred seventy-c of the labor law, farms, and farmers' markets, as such term is defined in section two hundred sixty of the agriculture and markets law, which feature displays of live animals that patrons may reasonably be expected to come into physical contact with for the purpose of touching, holding or petting shall provide hand washing or hand cleansing facilities for such patrons. Hand washing or hand cleansing facilities may be temporary or permanent fixtures and shall include one or more of the following: soap and running water; anti-bacterial fluids, foams or gels; or anti-bacterial or antiseptic wipes or towels.

2. Signs shall be conspicuously posted and shall state in a clear and legible typeface, the following: "Animals may carry germs and bacteria that can cause disease to people. It is strongly recommended that persons wash or cleanse their hands after touching, holding or petting the animals." Such signs shall also indicate where the hand washing or hand cleansing facility is located.

3. The commissioner may make rules guarding against the spread of bacteria and viruses at public establishments that feature animals as provided in subdivision one of this section, to persons employed at or to patrons of such establishments where such establishments are located outside the city of New York, and where such establishments are located within the city of New York, the commissioner of public health of the city of New York may make and enforce such rules.

TITLE II

NOXIOUS WEEDS AND GROWTHS

Section 1320. Noxious weeds and growths; declaration of nuisance.

1321. Noxious weeds and growths; notice to abate; enforcement.

§ 1320. Noxious weeds and growths; declaration of nuisance. 1.

Whenever in any health district there shall be growing on any property therein any ragweed or other species of weed, plant or growth which is noxious or detrimental to the public health, or the seed, pollen or other emanation therefrom, when carried through the air or otherwise dispersed, is noxious or detrimental to the public health, the local board of health of any such health district may take and file upon its records what it shall regard as sufficient proof to authorize a declaration that the existence of any such growth is a nuisance or danger to the public health, and may thereupon enter the same upon its records as a nuisance and order the same to be removed, destroyed or otherwise abated on any property wherever found.

2. The local board of health may also take and file among its records what it shall regard as sufficient proof to authorize a declaration that at any season or period of the year there exists a particular and imminent danger to the public health by reason of the approaching period of pollination of any such growth and may enter such determination upon its record.

§ 1321. Noxious weeds and growths; notice to abate; enforcement. 1.

In addition to the mode of service of any notice or order of any local board of health authorized by any other section of this chapter, and during the period or season when a particular and imminent danger to public health arising out of the pollination of weeds, plants or growths is determined to exist, any such local board of health may order the destruction of such weeds, plants or growths and the disposition thereof by posting a copy of such order conspicuously on the property where such noxious weeds, plants, or growths are found, requiring the destruction or other disposition thereof as shall be directed by such order. The posting of such order shall be sufficient notice of such order to the owner, lessee, occupant of, or principal person or persons interested in such property, of the nuisance created by such weeds, plants or growths.

2. If any such order is not complied with, or so far complied with as the local board of health shall regard as reasonable, within five days after service, or within a shorter time, which, in case of particular and imminent danger to the public health the local board of health may designate, such local board of health or other agency of the municipality or county may enter upon any such property and remove and destroy any weeds, plants and growths noxious or detrimental to the public health.

3. The provisions of sections thirteen hundred six and thirteen hundred seven of this chapter shall apply respecting the expense of such removal, destruction or abatement, except where a different method of collecting such expense is otherwise provided by law for and in respect to any health district, then and in that event the provisions of such law in connection therewith shall apply in the case of such health district.

4. The provisions of this section and of section thirteen hundred twenty of this chapter shall not operate to deprive the local legislative body of any municipality or county of the power to enact local laws in relation to any matter in respect to which such power would otherwise exist, nor shall it limit such power. If this power otherwise exists, any provision of this section and of section thirteen hundred twenty of this chapter may be superseded, supplemented or amended by local law in the same manner and to the same extent as such provisions could be superseded, supplemented or amended had this section and section thirteen hundred twenty of this chapter not been enacted.

TITLE III

TENEMENT HOUSE SANITATION

Section 1325. Tenement houses in cities; power of commissioner.

§ 1325. Tenement houses in cities; power of commissioner. 1. The commissioner shall have power to examine into the enforcement of the laws relating to tenement houses in any city.

2. Whenever required by the governor, the commissioner shall make such an examination and shall report the results thereof to the governor within the time prescribed by him therefor.

TITLE IV

LABOR CAMP SANITATION

Section 1330. Labor camps; violations; notice; injunction; administrative proceedings.

§ 1330. Labor camps; violations; notice; injunction; administrative proceedings. 1. When it appears to an officer that there has been a violation of the public health law or sanitary code at or in relation to any labor camp and such violation continues two days after written notice and demand for the discontinuance thereof, served as provided herein, he shall proceed pursuant to subdivision two or three of this section with respect to such violation.

2. An officer may institute proceedings to enjoin the continuance of such violation or the continued operation of such camp and, for purposes of such proceedings, a violation of any provision of the public health law or of the sanitary code shall be considered a public nuisance which may be enjoined or restrained. No bond or undertaking shall be required of such officer in such proceedings and no application to vacate or modify any judgment obtained shall be entertained by any court without proof to such court that ten days notice of such application, and copies of the papers upon which the application is to be made, have been served upon such officer.

3. (a) A hearing may be held, upon notice of not less than three days, before an officer or his representative. The officer shall make a determination with respect to any alleged violation and may assess a penalty not to exceed one hundred dollars for each violation, provided that (i) if the respondent establishes that a violation which existed prior to the service of the notice of hearing ceased to exist on or

prior to the date originally set for the hearing and has not reoccurred, then any penalty assessed for such violation shall be suspended on the condition that it will not reoccur during the next twenty-four months or (ii) for initial violations only which do not involve a serious and immediate risk to health or safety, if, prior to the date originally set for the hearing, an application for a loan for a farmworker housing project is made pursuant to section five hundred seventy-six-d of the private housing finance law and a satisfactory plan for curing the conditions giving rise to the violation is submitted to and approved by the department, then any penalty assessed may be vacated if such violation is cured within a reasonable period of time. In assessing a penalty hereunder, consideration shall be given to good faith efforts to cure the violation made on or prior to the date originally set for the hearing. A violation which continues for more than one day after the expiration of the two days for compliance provided for in subdivision one shall be considered to be a separate violation for each day that it continues after such notice and demand for discontinuance have been served.

(b) The notice of hearing also may provide that the labor camp may be ordered vacated if such an order is determined to be necessary for the health and safety of its occupants or of the community in which it is located. If the notice of hearing contains this provision and such an order is determined to be necessary, then the officer shall issue such order.

(c) The hearing officer acting pursuant to this subdivision may issue subpoenas which shall be regulated by the civil practice law and rules.

4. Before the effective date of an order or judgment enjoining the continued operation of a camp pursuant to subdivision two or of an order directing the vacating of such camp pursuant to subdivision three, the officer shall notify the county agricultural agent, the representative of the nearest office of the state employment service, and the county social services commissioner.

5. A notice required by this section may be served upon the owner or operator of the camp in the same manner as a summons in a civil action, or by registered mail to such owner or operator at the address filed by

him in the department or county health department or, if an address is not so filed, to his last known address or place of residence.

6. An officer may request and shall receive from all public officers, departments and agencies of the state and its political subdivisions such cooperation and assistance as may be necessary or proper in the enforcement of the provisions of this section.

7. Nothing contained in this section shall be construed to limit the duty or power of an officer to act with regard to an immediate threat to the health of the occupants of a camp or the community in which it is located, or to alter or abridge any of the duties and powers now or hereafter existing in the commissioner, state district health officers, county boards of health, county commissioners of health, local boards of health or other public agencies or public officials, or any private party.

8. As used in this section, the term "officer" shall mean the commissioner, or the county commissioner of health or the state district health officer having jurisdiction.

TITLE V

SUPPRESSION OF CERTAIN BUSINESSES

Section 1335. Certain businesses prohibited; application.

1336. Certain businesses prohibited; enforcement; violation.

§ 1335. Certain businesses prohibited; application. 1. It shall not be lawful for any person to engage in or carry on the business of fat rendering, boneboiling or the manufacture of fertilizers or any business as a public nuisance within the corporate limits of any incorporated city of this state, or within a distance of three miles from the corporate limits of any incorporated city, provided, however, that nothing herein contained shall prevent the rendering of fresh killed cattle or swine.

2. This section shall not apply to the counties of Fulton, Wayne, Tompkins, Chautauqua, Orange, Dutchess, Erie, Monroe, Oneida, Onondaga, New York, Schoharie, Ulster, Greene, Cayuga, Cattaraugus, Niagara, Saratoga, Schenectady, Hamilton, Montgomery and Orleans.

§ 1336. Certain businesses prohibited; enforcement; violation. 1. All departments of health or the commissioner or commissioners thereof in any incorporated city of this state shall have power to enforce the provisions of section thirteen hundred thirty-five of this chapter.

2. Any person violating the provisions of section thirteen hundred thirty-five of this chapter shall, upon conviction thereof, be guilty of a misdemeanor.

TITLE VI

BATHING ESTABLISHMENTS

Section 1340. Bathing places; sanitary requirements.

1341. Bathing places; safety requirements; ropes and life preservers.

1342. Bathing places; violations; penalties; enforcement.

§ 1340. Bathing places; sanitary requirements. 1. It shall be unlawful for any person to maintain, either as owner or lessee, any bathing establishment of any kind, in this state, for the accommodation of persons, for pay, or any consideration, at a point less than five hundred feet from any sewer connection emptying therein, or thereat, so as to pollute in any way, the waters used by those using or hiring bathing houses at such bathing establishment.

2. It shall be the duty of the owner, lessee or any other person maintaining any bathing establishment of any kind:

(a) to provide separate toilet rooms, with water-closets properly provided with sanitary plumbing, constructed in a manner approved by the local board of health of the health district wherein the bathing

establishment is located, and in such a way as not to contaminate the waters used by the bathers; and,

(b) to thoroughly wash and disinfect, or cause to be thoroughly washed and disinfected, in a manner approved by the said local board of health, all bathing suits that have been hired or used, before re-hiring or permitting the use of the same again.

§ 1341. Bathing places; safety requirements; ropes and life preservers. 1. (a) It shall be the duty of every person maintaining, as owner or lessee, any bathing establishment of any kind along the seashore of this state for the accommodation of persons for pay, to provide, for the safety of such bathers, two lines of sound, serviceable and strong manila or hemp rope, not less than one inch in diameter, anchored at some point above high water, at the same distance apart as the lines of bathing houses, or space fronting on such beach occupied by him or them, is in width. From the two points at which such life-lines are so anchored, such life-lines shall be made to extend as far into the surf as bathing is ordinarily safe and free from danger of drowning to persons not expert in swimming, and at such points of safety, such lines shall be anchored and buoyed. From the two points of such lines so extended, anchored and buoyed, a third rope shall be extended, of a similar size, connecting the two extremities, and buoyed at such points as to be principally above the surface of the water, thereby inclosing a space within such lines and the beach within which bathing is believed to be safe. In addition thereto, there shall be sufficient ropes of a similar size as herein described, anchored from a point at high water mark and buoyed or anchored at a parallel line or within the outer cross rope, so as to have not more than a space of seventy-five feet from one rope to another; and

(b) Every person maintaining any such bathing establishment shall cause to be painted and posted in some prominent place upon the beach near such bathing houses the following words: "Bathing beyond the lines dangerous", and

(c) Such lines so placed, anchored and buoyed, and such notice so posted, shall be so maintained and continued by every person maintaining any such establishment, during the entire season of surf bathing.

2. (a) Every person maintaining any such bathing establishment shall also keep and provide in connection therewith, for the facilitating of the rescue of persons in danger of drowning, a surfboat or a personal watercraft as defined in subdivision thirty of section two of the navigation law and in compliance with the regulations of the commissioner. A surfboat shall be not less than sixteen feet long, on each side of which there shall be hanging ropes arranged so that persons in the water can easily catch hold of same, or be supported thereby. Such boats shall be equipped with two or more sets of oars and life-lines and life-belts, and at least one ring buoy or life preserver, with quarter-inch cotton line, not less than five hundred feet in length, with suitable reel attached thereto. In addition thereto, there shall be anchored on the shore, a suitable reel with a half-inch cotton line not less than five hundred feet in length, with a life-belt attached thereto, kept in good order and proper condition, so that it can readily be used by those assisting in saving life.

(b) At all bathing establishments where there are equipments for two hundred bathers or more, said surf or life-boat shall be stationed in the water, opposite the lines, manned and in readiness for use, during bathing hours.

3. Every person maintaining any such bathing establishment shall employ or otherwise engage or provide the services of a bathing master or life-guard at such bathing establishment, who shall be an expert swimmer, and who shall be in constant and watchful attendance during bathing hours.

4. The owner of a bathing establishment shall not be subject to the provisions of this section when it is used, occupied or maintained by a lessee for hire, but such lessee shall be deemed the keeper or proprietor or person maintaining such bathing establishment.

5. Nothing in this section shall be construed in any way to affect any bathing establishments, in any municipality, or any bathing establishments or bathing beaches operated by a regional state park commission, at which there is maintained at public expense a life-saving

guard.

§ 1342. Bathing places; violations; penalties; enforcement. 1. Any person violating any of the provisions of section thirteen hundred forty-one of this chapter, shall forfeit and pay a penalty of not less than fifty dollars, nor more than two hundred dollars to be recovered by the sheriff of the county in which such violation is committed, except in the city of New York, when the penalty shall be sued for in the name of the department of health of the city of New York and collected by it.

2. A separate penalty may be recovered for each day that any person subject to the provisions of this section may violate any of the provisions of the same; but no penalty shall be recovered for any other violation thereof than shall have occurred during the days when the owner or lessee, or other person, maintaining the said bathing establishments, shall have kept the same open for the use of the public, or for such persons as may be the guests of any hotel with which such bathing establishments may be connected.

3. It shall be the duty of the sheriffs and constables of the several counties of this state abutting upon the seashore, to see that in their respective counties the provisions of this section are enforced, and to bring suit for the recovery of the penalty therein provided, unless some other person had already brought suit for the same.

TITLE VII

HOTEL SANITATION

Section 1345. Hotel sanitation; sewage; ventilation.

1346. Hotel sanitation; bedding; sheets, towels, drinking glasses, silverware and flatware.

1347. Hotel sanitation; enforcement; violations.

1348. Hotel sanitation; application of article.

§ 1345. Hotel sanitation; sewage; ventilation. Every hotel shall be

well drained and ventilated and every hotel connected with a cesspool or located in any municipality having a sewer system shall be well ventilated, drained, plumbed and connected according to sanitary principles with such cesspool or sewer system, and shall be kept free from effluvia arising from sewer, drain, water-closet or other source within the control of the owner, manager, agent or other person in charge of said hotel.

§ 1346. Hotel sanitation; bedding; sheets, towels, drinking glasses, silverware and flatware. 1. Every hotel shall furnish each guest with clean linen or cotton individual towels in each room occupied by such guest, and also in the public lavatories and washrooms of such hotel, and with clean sheets and pillow slips for the bed, bunk, or cot to be occupied by such guest.

2. Every hotel that furnishes drinking glasses, silverware or flatware in individual rooms shall provide that such items are fully sanitized using proper techniques as provided for by the department.

3. Each sheet shall be ninety-one inches long, minimum length after being hemmed and laundered, and of sufficient width to completely cover the mattress and springs, and all sheets and pillow slips after being used by one guest must be washed, ironed and dried before being furnished to another guest.

4. Nothing in this section shall prevent local municipalities from enacting stricter laws, rules or regulations.

§ 1347. Hotel sanitation; enforcement; violations. 1. All departments and boards of health and the commissioner or commissioners thereof shall have the power to enforce the provisions of sections thirteen hundred forty-five to thirteen hundred forty-seven, inclusive, of this chapter.

2. The commissioners of health and the respective local boards of health and any person authorized by either of them so to do, may enter

any hotel or any part thereof at any reasonable time to inspect and examine the same, to determine whether or not the laws and regulations relating to hotels are being violated.

3. Any hotel proprietor or manager violating any of the provisions of sections thirteen hundred forty-five to thirteen hundred forty-seven, inclusive, of this chapter, is guilty of a misdemeanor.

§ 1348. Hotel sanitation; application of article. The provisions of sections thirteen hundred forty-five to thirteen hundred forty-seven, inclusive, of this chapter, shall not apply to cities having a population of one million inhabitants or over.

TITLE VIII FOOD HANDLING

- Section 1350. Food places; powers of the commissioner.
1351. Food places; duty to permit inspections.
1352. Food places; sanitary requirements.
- 1352-a. Food places; toilet facilities.
- 1352-b. Public eating establishments; first aid instructions concerning food lodged in throat; liability.
- 1352-c. Ice cream or other frozen desserts made with liquor, wine, beer or cider.
- 1352-d. Public food service establishment inspection results.
- 1352-e. Companion dogs at food service establishments.
1353. Food places; violations; penalties.
1354. Contracts for meat inspection.
1355. Food service safety and sanitation training.
1356. Food allergies and intolerances notice in food service establishments and online food ordering services.
1357. Allergen labeling for prepackaged foods.

§ 1350. Food places; powers of the commissioner. 1. The commissioner shall have full power and authority to inspect and supervise all public

places in this state in which food is prepared, sold or served.

2. The commissioner may appoint and designate, from time to time, persons to make the inspections authorized by this section and section thirteen hundred fifty-one, of this chapter.

§ 1351. Food places; duty to permit inspections. Every owner, operator, lessor, lessee or person in charge of any hotel, restaurant, dining room, dining car, drug store, soda fountain, steamboat or other place engaged in the preparation, sale or service of food for and to the general public, and every officer or other person in charge of any public, penal or charitable institution in this state, shall permit the commissioner or his duly authorized agents or employees to have access to all parts of any and all of such places herein mentioned wherein food is stored, prepared or served for the purpose of ascertaining whether the provisions of sections thirteen hundred fifty to thirteen hundred fifty-two, inclusive, of this chapter, and the provisions of the sanitary code and provisions of local ordinances or regulations are being observed.

§ 1352. Food places; sanitary requirements. 1. A person or corporation engaged in the preparation and sale of food in any hotel, public restaurant, public dining room, dining car, drug store, soda fountain, steamboat or in any other place where food is prepared, sold or served for and to the general public in this state, or an officer of any public, penal or charitable institution in this state, shall not use in the preparation or service of any food utensils, dishes, glasses or other containers which have not been previously cleansed and made sanitary. In such cleansing the use of water which has become unsanitary by previous use is prohibited.

2. It shall be unlawful to furnish or serve in any public eating or drinking establishment, any straw, tube or similar device for drinking out of glasses, cups or containers of any type unless such straw, tube or similar device conforms to and is furnished or served in accordance

with the following requirements: When offered for use, it shall be completely enclosed in an impervious or a bactericidal wrapper to be opened by the ultimate user; if unwrapped it may be used if it is kept in an approved sanitary dispenser loaded from the original package without handling, which dispenses one such straw, tube or device at a time directly to the user and which is so constructed that the interior may be cleaned and kept in a sanitary condition; unused loose straws, tubes or devices already dispensed from the dispensing container shall not be used again. No single-service paper containers, paper cups, paper spoons, paper forks or paper plates shall be used a second time.

3. The commissioner shall require in food service establishments, as defined in the state sanitary code, for foods to be conveyed to the consumer uncooked and for foods handled after being cooked but prior to being conveyed to the consumer, that such food not come into direct manual contact with persons responsible for preparing or serving the food. Sanitary gloves, sanitary utensils or other effective barriers shall be utilized to avoid manual contact in the preparation and conveyance of these foods to the consumer. In preparing regulations pursuant to this subdivision, the commissioner may provide for an alternate standard that would permit minimal manual contact based upon finding that such alternate standard would protect worker safety and not compromise consumer health. In preparing regulations the commissioner shall consult with representatives of the food service industry, including workers in the industry.

4. To the extent that funds are available for the purposes set forth in this subdivision, the commissioner shall require that the following food service establishments: restaurants, bars, membership organizations, fraternal organizations, and private clubs, excepting establishments licensed pursuant to section sixty-four-a of the alcoholic beverage control law, that are not regulated by the department of agriculture and markets, at all times have in their employment at least one individual who has been trained and certified by an organization, approved by the commissioner, which specializes in and provides instruction concerning the safe and proper handling, preparation, cooking, storage, serving, delivery, removal and disposal

of food. Attendance at any course established pursuant to this section shall be in person, through distance learning methods, or through an Internet based online program. Such training shall meet the standards set forth by the commissioner pursuant to section thirteen hundred fifty-five of this title, either: (a) pursuant to a program approved by the commissioner under such section, or (b) pursuant to a course that shall address but not be limited to the following topics:

- (i) Contamination, food allergies and foodborne illness.
- (ii) Purchasing and receiving safe food.
- (iii) Keeping food safe in storage.
- (iv) Protecting food during preparation.
- (v) Protecting food during service.
- (vi) Sanitary facilities and equipment.
- (vii) Cleaning and sanitizing.
- (viii) Integrated pest management.
- (ix) Food-safety regulations and standards.
- (x) Employee food-safety training.

The commissioner shall allow a licensee a period of up to thirty days to come into compliance with this subdivision where an employee who has been certified as having completed the approved food safety training program separates from his or her place of employment.

§ 1352-a. Food places; toilet facilities. 1. A person or corporation operating an establishment with a seating capacity of twenty or more wherein food is sold for consumption on the premises shall provide appropriately identified and maintained public toilet facilities except that if there exists alternate available facilities in the same building wherein such establishment is located, suitable public notice of such alternate facility shall suffice for purposes of this act.

2. The provisions of subdivision one of this section shall not apply to establishments in operation on the effective date of this act.

§ 1352-b. Public eating establishments; first aid instructions

concerning food lodged in throat; liability. 1. Definitions. For purposes of this section:

a. "Public eating establishment" shall mean a cafeteria or lunchroom located in a school or educational institution and a restaurant, dining room, dining car or other place engaged in the preparation and service on the premises of food for and to the general public;

b. "Choking emergency" shall mean a situation occurring in a public eating establishment in which food has become lodged in a person's throat in such a manner as to prevent or severely inhibit the continued breathing of such person.

2. First aid instructions. a. The commissioner shall adopt and approve first aid instructions designed and intended for use in removing food lodged in the throat of a victim of a choking emergency. Such instructions shall be limited to first aid techniques not involving the use of any physical instrument or device to be inserted into the victim's mouth or throat.

b. The commissioner shall, as soon as is practicable, supply to the proprietor of every public eating establishment in this state such adopted and approved instructions.

3. Posting. The proprietor of every public eating establishment in this state shall, upon receipt thereof, post such instructions in a conspicuous place or places in order that the proprietor and employees may become familiar with them, and in order that the instructions may be consulted by any person attempting to provide relief to the victim of a choking emergency; provided, that the fact that such instructions shall not have been posted as required by this section at the time of a choking emergency shall not in and of itself subject such a proprietor, or his employees or agents, to liability in any civil action for damages for personal injuries or wrongful death arising from such choking emergency.

4. No duty to act. Nothing contained in this section shall impose any

duty or obligation on any proprietor, employee or other person to remove, assist in removing, or attempt to remove food from the throat of the victim of a choking emergency.

5. Immunity from liability. Notwithstanding any inconsistent provision of law or ordinance, a proprietor, employee or other person who voluntarily and without expectation of monetary compensation removes, assists in removing, or attempts to remove food from the throat of the victim of a choking emergency in accordance with the instructions adopted by the commissioner shall not be liable for damages for injuries alleged to have been sustained by such victim or for damages for the death of such victim alleged to have occurred by reason of an act or omission in the rendering of such emergency assistance unless it is established that such injuries were, or such death was, caused by gross negligence on the part of such proprietor, employee or person.

§ 1352-c. Ice cream or other frozen desserts made with liquor, wine, beer or cider. No person shall sell at retail individual servings of ice cream or other frozen desserts made with liquor, wine, beer or cider bearing or containing more than one-half of one percent but not more than five percent of alcohol by volume, unless the following statements are prominently displayed on the printed menu (or, if no printed menus are used, on the menu board or sign setting forth the bill of fare) immediately adjacent to the listing of the item or items of ice cream or other frozen desserts made with liquor, wine, beer or cider being offered provided that such statements may refer to liquor, wine, beer or cider or a combination thereof:

1. The sale of (insert liquor, wine, beer and/or cider) ice cream or other frozen desserts to individuals under the age of twenty-one is prohibited.

2. (Insert liquor, wine, beer and/or cider) ice cream or other frozen desserts contain alcohol up to five percent by volume.

3. Notice: (Insert liquor, wine, beer and/or cider) ice cream or other

frozen desserts contain alcohol used as a flavoring and, as with any product that contains alcohol:

(a) women should not consume alcohol during pregnancy because of the risk of birth defects, and

(b) consumption of alcohol impairs your ability to drive a car or operate machinery, and may cause health problems.

§ 1352-d. Public food service establishment inspection results. 1. (a) The department shall make available and prominently post on its website all public food service establishment inspection results for the most recent three years for which data is available, which shall include the determination concerning any alleged violation of this title.

(b) As used in this section, "its website" means a website or a portion of a website maintained by an entity of state government on which the department regularly posts departmental information.

(c) If a county department of health or local board of health maintains a website, it shall post a link to the department's website where the food service establishment inspection results are available.

2. A city with a population over one million shall be exempted from the provisions of this section.

§ 1352-e. Companion dogs at food service establishments. 1. Companion dogs under the control of a person may be allowed in an outdoor dining area at a food service establishment if all of the following conditions are satisfied:

(a) the owner of the food facility elects to allow companion dogs in its outdoor dining area or a designated portion of it, and subject to any restrictions that the owner of the facility may establish;

(b) a separate outdoor entrance is present where companion dogs enter without going through the food establishment to reach the outdoor dining area and companion dogs are not allowed on chairs, benches, seats or other fixtures;

(c) the outdoor dining area in which companion dogs are allowed is not used for food or drink preparation or the storage of utensils. A food

employee may refill a beverage glass in the outdoor dining area from a pitcher or other container;

(d) food and water provided to companion dogs shall only be in single-use disposable containers;

(e) food employees are prohibited from having direct contact with companion dogs while on duty. A food employee who does have such prohibited direct contact shall wash his or her hands as required by law;

(f) the outdoor dining area is maintained clean. Surfaces that have been contaminated by dog excrement or other bodily fluids shall be cleaned and sanitized;

(g) the companion dog is on a leash or confined in a pet carrier and is under the control of the companion dog owner;

(h) there is reasonable signage indicating that companion dogs are allowed in the outdoor dining area or a designated portion of it. The signage shall state that restrictions on companion dogs do not apply to guide, hearing or service animals;

(i) the food facility owner ensures compliance with local ordinances related to sidewalks, public nuisance and sanitation; and

(j) such other control measures approved by the enforcement agency are complied with.

2. This section shall not impair or diminish the right of an individual to be accompanied by an animal where otherwise permitted by law, including but not limited to the rights of people with disabilities using guide, hearing or service animals.

3. For purposes of this section:

(a) "Food service establishment" shall mean any business which has areas, including outdoor seating areas, in which food is sold for on-premises consumption.

(b) "Companion dog" shall mean a domesticated dog accompanying an individual or owner for the purpose of companionship or convenience of such individual or owner, and shall not include guide, hearing or service dogs.

§ 1353. Food places; violations; penalties. 1. Any person or corporation, or officer thereof, violating any of the provisions of sections thirteen hundred fifty to thirteen hundred fifty-three, inclusive, of this chapter, shall be guilty of a misdemeanor.

2. The conviction of a corporation shall not relieve any officer or officers, agents or employees of such corporation from prosecution under the provisions of sections thirteen hundred fifty to thirteen hundred fifty-three, inclusive, of this chapter.

§ 1354. Contracts for meat inspection. When a board of health of a county or part county health district or a city, or a public health committee of a county has made application to the commissioner for approval of a meat inspection program and providing such application has been approved by the commissioner, the board of supervisors of any such county or the common council of any such city, may approve and enter into a contract with another county or city for inspection in such county or city which has no meat inspection program. The county or city receiving such meat inspection shall pay to the county or city doing the meat inspection an amount agreed upon but not less than the actual cost of any such meat inspection. Any county or city may accept contributions from any individual, company or corporation which receives the benefit of any meat inspection.

§ 1355. Food service safety and sanitation training. 1. The commissioner shall promulgate rules and regulations (a) establishing food service safety and sanitation training programs and providing standards therefor or (b) providing for the approval of such programs to be administered by local health officials or private parties in accordance with such rules and regulations.

2. Such regulations shall include a provision permitting private citizens working in establishments subject to the jurisdiction of the commissioner pursuant to this title to attend such training program.

§ 1356. Food allergies and intolerances notice in food service establishments and online food ordering services. 1. Definitions. For the purposes of this section:

(a) "Food service establishment" shall mean a restaurant or catering hall where food is prepared and served either on or off site.

(b) "Menu" shall mean a list or pictorial display of a prepared food item or items available for sale from a food establishment for the purpose of permitting a customer to order such food item or items, including such list or pictorial display posted online for a customer to place food orders for delivery or take out.

2. The commissioner shall make available on the department's website, in English and in the twelve most common non-English languages spoken by limited-English proficient individuals in the state, based on the data in the most recent American Community Survey published by the United States Census Bureau, a notice containing information for staff of food service establishments regarding food allergies and intolerances. Such notice shall include:

(a) the procedures to be followed if a customer informs staff of such food service establishment that such customer has a food allergy or intolerance;

(b) any procedures to be followed to prevent cross contact; and

(c) the procedure to be followed if a customer has an allergic reaction, including a recommendation regarding the circumstances in which to call 911.

3. Every food service establishment shall post the notice containing information on food allergies and intolerances established pursuant to subdivision two of this section in a conspicuous location accessible to all employees involved in the preparation or service of food, in at least one of the languages spoken by each employee to the extent such languages are among those in which the department makes the notice available pursuant to subdivision two of this section.

4. The commissioner shall make available on the department's website, in the twelve most common non-English languages spoken by

limited-English proficient individuals in the state, based on the data in the most recent American Community Survey published by the United States Census Bureau, (a) a translation of the following: "If you have a food allergy or intolerance, please notify us."; and (b) a food allergy or intolerance message that food service establishments may use to inform customers about allergy and intolerance information for prepared food items.

5. Every food service establishment operating in New York state that makes available a menu shall include in a conspicuous manner on each menu or the assembly upon which the menu or menus are included, either, (a) the following notice: "If you have a food allergy or intolerance, please notify us."; or (b) a food allergy or intolerance message that informs the customer about the allergy or intolerance information for each prepared food item or items on such menu. If such menu is available in a language other than English for which the department makes a translation available pursuant to subdivision four of this section, such food service establishment shall also include such translation in a conspicuous manner. Every food service establishment that makes available a menu online for a customer to place food orders for delivery or take out, including under a third-party food delivery agreement pursuant to section three hundred ninety-one-v of the general business law, shall also include on such menu a food allergy or intolerance notification to customers and either, (1) provide a method by which a customer may indicate any food allergy or intolerance such customer has; or (2) provide a food allergy message that informs the customer about the allergy and intolerance information for each prepared food item or items on such menu.

6. Any food service establishment that violates the provisions of this section or any of the rules or regulations promulgated hereunder shall be liable for a civil penalty not to exceed one hundred twenty-five dollars for each violation.

*** § 1357. Allergen labeling for prepackaged foods.** 1. As used in this section, the following terms shall have the following meanings:

(a) "Prepackaged food" means food that is prepared, prepacked and offered or sold to customers on the same premises. Prepackaged food does not include food that is not in packaging or is packaged after a customer has ordered.

(b) "Food establishment" means any place food is prepared and intended for off-premises consumption, including all delis, bakeries, sandwich shops, ice cream parlors, cafeterias and food trucks operating within the state.

(c) (i) "Major food allergen" means:

(A) milk, eggs, fish, crustacean shellfish, tree nuts, wheat, peanuts, sesame, and soybeans; and

(B) a food ingredient that contains protein derived from a food named in clause (A) of this subparagraph.

(ii) "Major food allergen" does not include:

(A) any highly refined oil derived from a food specified in clause (A) of subparagraph (i) of this paragraph or any ingredient derived from such highly refined oil; or

(B) any ingredient that is exempt under the petition or notification process specified in the Food Allergen Labeling and Consumer Protection Act of 2004, as amended.

2. Every food establishment shall label all prepackaged food with a written notification on the package or on a label attached to the package identifying any ingredient with which a product is made that constitutes a major food allergen. Such label need not identify any ingredient that does not constitute a major food allergen under federal or state law.

* NB Effective November 12, 2026

* TITLE IX

LOCATION AND DISPOSITION OF RADIOACTIVE GOLD JEWELRY

Section 1360. Location and disposition of radioactive gold jewelry.

* NB Expired July 21, 1982

* § 1360. Location and disposition of radioactive gold jewelry. 1.

The commissioner is hereby authorized and directed to establish a program, which shall include the use of such investigations and personnel as may be necessary, to identify gold jewelry which has been contaminated by radioactive material which is, or may be, possessed by residents of this state. Such program shall be publicized by the commissioner, as may be practicable, to encourage residents to have such suspected radioactive gold jewelry tested free of charge, except that jewelers, manufacturers or distributors of gold jewelry may be charged a reasonable fee for the cost of such tests, as determined by the commissioner.

2. Notwithstanding any contrary provisions of law, in any case where such gold jewelry is so identified as radioactive, the commissioner is hereby authorized and empowered to purchase from a resident on behalf of the state such radioactive gold jewelry presented by such resident at the commercial value of the gold content of the radioactive gold jewelry, upon such terms and conditions as the commissioner deems necessary and proper, and within the amount appropriated by the legislature for this purpose.

3. Any such gold jewelry, purchased pursuant to the provisions of this section, shall be held decontaminated or disposed of in such a manner as shall be determined necessary and proper by the commissioner which disposition, however, may include, but not be limited to, the destruction thereof.

4. Any person, firm, association or corporation who learns that they possess radioactive gold jewelry shall immediately notify the commissioner or his designee of the existence of such radioactive gold jewelry.

* NB Expired July 21, 1982

TITLE X

CONTROL OF LEAD POISONING

Section 1370. Definitions.

1370-a. Lead poisoning prevention program.

- 1370-b. Advisory council on lead poisoning prevention.
- 1370-c. Screening by health care providers.
- 1370-d. Lead screening of child care or pre-school enrollees.
- 1370-e. Reporting lead exposure levels.
- 1371. Manufacture and sale of lead painted toys and furniture.
- 1372. Use of leaded paint.
- 1373. Abatement of lead poisoning conditions.
- 1374. Receivership.
- 1375. Enforcement agencies.
- 1376-a. Sale of consumer products containing lead or cadmium.
- 1377. State rental registry and proactive inspections to identify lead hazards.

§ 1370. Definitions. When used in this title, the following words and phrases shall have the following meanings, unless the context clearly requires otherwise:

1. "Dwelling" means a building or structure or portion thereof, including the property occupied by and appurtenant to such dwelling, which is occupied in whole or in part as the home, residence or sleeping place of one or more human beings and shall, without limiting the foregoing, include child care facilities for children under six years of age, kindergartens and nursery schools.

2. "Area of high risk" means an area designated as such by the commissioner or his representative and consisting of one or more dwellings in which a condition conducive to lead poisoning of children is present.

3. "A condition conducive to lead poisoning" means: (i) paint or other similar surface-coating material containing lead in a condition accessible for ingestion or inhalation or where peeling or chipping of the paint or other similar surface-coating material occurs or is likely to occur; and (ii) other environmental conditions which may result in significant lead exposure.

4. "Program" means the lead poisoning prevention program in the department established pursuant to section thirteen hundred seventy-a of this title.

5. "Council" means the advisory council on lead poisoning prevention established pursuant to section thirteen hundred seventy-b of this title.

6. "Elevated lead levels" means a blood lead level greater than or equal to five micrograms of lead per deciliter of whole blood or such lower blood lead level as may be established by the department pursuant to rule or regulation.

7. "Person" means any natural person.

* 8. "Owner" means and includes the owner or owners of the freehold of the premises or lesser estate therein, a mortgagee or vendee in possession, assignee of rents, receiver, executor, trustee, lessee, agent, or any other person, firm or corporation, directly or indirectly in control of a dwelling.

* NB Repealed November 3, 2028

§ 1370-a. Lead poisoning prevention program. 1. The department shall establish a lead poisoning prevention program. This program shall be responsible for establishing and coordinating activities to prevent lead poisoning and to minimize risk of exposure to lead. The department shall exercise any and all authority which may be deemed necessary and appropriate to effectuate the provisions of this title.

2. The department shall:

(a) promulgate and enforce regulations for screening children and pregnant women, including requirements for blood lead testing, for lead poisoning, and for follow up of children and pregnant women who have elevated blood lead levels;

(b) enter into interagency agreements to coordinate lead poisoning prevention, exposure reduction, identification and treatment activities and lead reduction activities with other federal, state and local

agencies and programs;

(c) establish a statewide registry of lead levels of children provided such information is maintained as confidential except for (i) disclosure for medical treatment purposes; (ii) disclosure of non-identifying epidemiological data; and (iii) disclosure of information from such registry to the statewide immunization information system established by section twenty-one hundred sixty-eight of this chapter;

(d) develop and implement public education and community outreach programs on lead exposure, detection and risk reduction;

(e) require primary health care providers to provide the parent or guardian of each child under six years of age anticipatory guidance on lead poisoning prevention as part of routine care, including but not limited to contact information for the state-designated childhood lead poisoning primary prevention program serving their county; and

(f) develop and update as necessary, in consultation with the New York state advisory council on lead poisoning prevention, a standardized lead exposure risk assessment questionnaire that shall be available on the department's website for primary health care providers to utilize pursuant to subdivision two-a of section thirteen hundred seventy-c of this title.

3. The department shall identify and designate areas in the state with significant concentrations of children identified with elevated blood lead levels as communities of concern for purposes of implementing a childhood lead poisoning primary prevention program, and may, within amounts appropriated, provide grants to implement approved programs. The commissioner of health of a county or part-county health district, a county health director or a public health director and, in the city of New York, the commissioner of the New York city department of health and mental hygiene, shall develop and implement a childhood lead poisoning primary prevention program to prevent exposure to lead-based paint hazards for the communities of concern in their jurisdiction. The department shall provide funding to the New York city department of health and mental hygiene or county health departments to implement the approved work plan for a childhood lead poisoning primary prevention program. The work plan and budget, which shall be subject to the approval of the department, shall include, but not be limited to: (a)

identification and designation of an area or areas of high risk within communities of concern; (b) a housing inspection program that includes prioritization and inspection of areas of high risk for lead hazards, correction of identified lead hazards using effective lead-safe work practices and, appropriate oversight of remediation work; (c) partnerships with other county or municipal agencies or community-based organizations to build community awareness of the childhood lead poisoning primary prevention program and activities, coordinate referrals for services, and support remediation of housing that contains lead hazards; (d) a mechanism to provide education and referral for lead testing for children and pregnant women to families who are encountered in the course of conducting primary prevention inspections and other outreach activities; and (e) a mechanism and outreach efforts to provide housing inspections for lead hazards upon request. The commissioner of health of a county or part-county health district, a county health director or a public health director and, in the city of New York, the commissioner of the New York city department of health and mental hygiene, shall also enter into an agreement or subcontract with a municipal government regarding inspection of the paint conditions in dwellings built prior to nineteen hundred seventy-eight for the area defined as the community of concern and may, when qualified staff exists, designate the local housing maintenance code enforcement agency in which the community of concern is located as an agency authorized to administer the provisions of this title pursuant to subdivision one of section thirteen hundred seventy-five of this title. A portion of grant funding received to support the local primary prevention plan may be used to reduce barriers to lead testing of children and pregnant women within the communities of concern, including the purchase of lead testing devices and supplies when the need for such resources is identified within the community. The commissioner, the commissioner of health of a county or part-county health district, a county health director or a public health director and, in the city of New York, the commissioner of the New York city department of health and mental hygiene, is authorized to enter into agreements, contracts, subcontracts or memoranda of understanding with, and provide technical and other resources to, local health officials, local building code officials, real property owners, and community organizations in such areas to

create and implement policies, education and other forms of community outreach to address lead exposure, detection and risk reduction. Primary prevention plans shall target children less than six years of age living in the highest risk housing in the communities of concern identified. The plans shall also take into consideration the extent the weatherization assistance program and other such programs can be used in conjunction with lead-based paint hazard risk reduction. Funding provided for this program shall be used for the activities described in this section and shall not be used for other activities required by this title.

§ 1370-b. Advisory council on lead poisoning prevention. 1. The New York state advisory council on lead poisoning prevention is hereby established in the department, to consist of the following, or their designees: the commissioner; the commissioner of labor; the commissioner of environmental conservation; the commissioner of housing and community renewal; the commissioner of children and family services; the commissioner of temporary and disability assistance; the secretary of state; and fifteen public members appointed by the governor. The public members shall have a demonstrated expertise or interest in lead poisoning prevention and at least one public member shall be representative of each of the following: local government; community groups; labor unions; real estate; industry; parents; educators; local housing authorities; child health advocates; environmental groups; professional medical organizations and hospitals. The public members of the council shall have fixed terms of three years; except that five of the initial appointments shall be for two years and five shall be for one year. The council shall be chaired by the commissioner or his or her designee.

2. Members of the advisory council shall serve without compensation for their services, except that each of them may be allowed necessary and actual expenses which he or she shall incur in the performance of his or her duties under this article.

3. A majority of the appointed voting membership of the council shall

constitute a quorum.

4. The council shall meet as often as may be deemed necessary to fulfill its responsibilities. The council shall have the following powers and duties:

(a) To develop a comprehensive statewide plan to prevent lead poisoning and to minimize the risk of human exposure to lead;

(b) To coordinate the activities of its member agencies with respect to environmental lead policy and the statewide plan;

(c) To recommend the adoption of policies with regard to the detection and elimination of lead hazards in the environment;

(d) To recommend the adoption of policies with regard to the identification and management of children with elevated lead levels;

(e) To recommend the adoption of policies with regard to education and outreach strategies related to lead exposure, detection, and risk reduction;

(f) To comment on regulations of the department under this title when the council deems appropriate;

(g) To make recommendations to ensure the qualifications of persons performing inspection and abatement of lead through a system of licensure and certification or otherwise;

(h) To recommend strategies for funding the lead poisoning prevention program, including but not limited to ways to enhance the funding of screening through insurance coverage and other means, and ways to financially assist property owners in abating environmental lead, such as tax credits, loan funds, and other approaches; and

(i) To report on or before December first of each year to the governor and the legislature concerning the previous year's development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary and the most currently available lead surveillance measures, including the actual number and estimated percentage of children tested for lead in accordance with New York state regulations, including age-specific testing requirements, and the actual number and estimated percentage of children identified with elevated blood lead levels. Such report shall be made available on the department's website.

§ 1370-c. Screening by health care providers. 1. The department is authorized to promulgate regulations establishing the means by which and the intervals at which children and pregnant women shall be screened for elevated lead levels. The department is also authorized to require screening for lead poisoning in other high risk groups.

2. Every physician or other authorized practitioner who provides medical care to children or pregnant women, shall screen children or refer them for screening for elevated lead levels at the intervals and using the methods specified in such regulations. Every licensed, registered or approved health care facility serving children including but not limited to hospitals, clinics and health maintenance organizations, shall ensure, by providing screenings or by referring for screenings, that their patients receive screening for lead at the intervals and using the methods specified in such regulations.

2-a. Every primary health care provider shall conduct a lead exposure risk assessment questionnaire provided by the department for each child who is at least six months of age and continuing until six years of age at each routine well-child visit, or at least annually if a child has not had routine well-child visits.

3. The health practitioner who screens any child for lead shall give a certificate of screening to the parent or guardian of the child.

4. The department shall establish a separate level of payment, subject to the approval of the director of the budget, for payments made by governmental agencies for screenings performed pursuant to this section by hospitals, as defined in section twenty-eight hundred one of this chapter.

§ 1370-d. Lead screening of child care, pre-school, pre-kindergarten or kindergarten enrollees. 1. Except as provided pursuant to regulations of the department, each child care provider, public and private nursery school, pre-school, and pre-kindergarten or kindergarten licensed,

certified or approved by any state or local agency shall, prior to or within three months after initial enrollment of a child under six years of age, obtain from a parent or guardian of the child evidence that said child has been screened for lead.

2. Whenever there exists no evidence of lead screening as provided for in subdivision one of this section or other acceptable evidence of the child's screening for lead, the child care provider, principal, teacher, owner or person in charge of the nursery school, pre-school, or pre-kindergarten or kindergarten shall provide the parent or guardian of the child with information on lead poisoning in children and lead poisoning prevention and refer the parent or guardian to a primary care provider or the local health authority.

3. (a) If any parent or guardian to such child is unable to obtain lead testing, such person may present such child to the health officer of the county in which the child resides, who shall then perform or arrange for the required screening.

(b) The local public health district shall develop and implement a fee schedule for households with incomes in excess of two hundred percent of the federal poverty level for lead screening pursuant to section six hundred six of this chapter, which shall vary depending on patient household income.

§ 1370-e. Reporting lead exposure levels. 1. Every physician or authorized practitioner shall give notice of elevated lead levels as specified by the commissioner pursuant to regulation, to the health officer of the health district wherein the patient resides, except as otherwise provided.

2. The commissioner may, by regulation, provide that cases of elevated lead levels which occur (a) in health districts of less than fifty thousand population not having a full-time health officer, or (b) in state institutions shall be reported directly to the department or its district health officer.

3. Whenever an analysis of a clinical specimen for lead is performed by a laboratory or a physician or authorized practitioner, the director of such laboratory or such physician or authorized practitioner shall, within such period specified by the commissioner report the results and any related information in connection therewith to the local and state health officer to whom a physician or authorized practitioner is required to report such cases pursuant to this section.

4. The person in charge of every hospital, clinic, or other similar public or private institution shall give notice of every child with an elevated blood lead level coming under the care of the institution to the local or state health officer to whom a physician or authorized practitioner is required to report such cases pursuant to this section.

5. The notices required by this section shall be in a form and filed in such time period as shall be prescribed by the commissioner.

§ 1371. Manufacture and sale of lead painted toys and furniture. 1. No person shall manufacture, sell or hold for sale a children's toy or children's furniture having paint or other similar surface-coating material thereon containing more than .06 of one per centum of metallic lead based on the total weight of the contained solids or dried paint film.

2. The commissioner of health may waive the provisions of this section in whole or in part upon a finding by the commissioner in a particular instance that there is no significant threat to the public health; with respect to miniatures the commissioner shall do so, on terms and conditions he or she shall establish, upon a final judicial or administrative finding that there is no immediate public health threat in that instance.

§ 1372. Use of leaded paint. No person shall apply paint or other similar surface-coating material containing more than .06 of one per centum of metallic lead based on the total weight of the contained

solids or dried paint film to any interior surface, window sill, window frame or porch of a dwelling.

§ 1373. Abatement of lead poisoning conditions. 1. Whenever the commissioner or his or her representative shall designate an area of high risk, he or she shall give written notice and demand, served as provided by this section, for the discontinuance of a paint condition conducive to lead poisoning in any designated dwelling in such area within a specified period of time.

2. Such notice and demand shall prescribe the method of discontinuance of a condition conducive to lead poisoning which may include the removal of paint containing more than one-half of one per centum of metallic lead based on the total weight of the contained solids or dried film of the paint or other similar surface-coating material from surfaces specified by the commissioner or his representative under such safety conditions as may be indicated and the refinishing of such surfaces with a suitable finish which is not in violation of section one thousand three hundred seventy-two of this title or the covering of such surfaces with such material or the removal of lead contaminated soils or lead pipes supplying drinking water as may be deemed necessary to protect the life and health of occupants of the dwelling.

3. In the event of failure to comply with a notice and demand, the commissioner or his or her representative shall take enforcement action as deemed appropriate by the commissioner or his or her representative, which may include conducting a formal hearing upon due notice in accordance with the provisions of section twelve-a of this chapter and on proof of violation of such notice and demand may order abatement of a paint condition conducive to lead poisoning upon such terms as may be appropriate and may assess a penalty not to exceed two thousand five hundred dollars for such violation; provided, however, that abatement shall not be ordered if the respondent proves by a preponderance of evidence at such hearing that a paint condition conducive to lead poisoning in the designated dwelling does not exist.

4. A notice required by this section may be served upon an owner or occupant of the dwelling or agent of the owner in the same manner as a summons in a civil action or by registered or certified mail to his last known address or place of residence.

5. The removal of a tenant from or the surrender by the tenant of a dwelling with respect to which the commissioner or his representative, pursuant to subdivision one of this section, has given written notice and demand for the discontinuance of a paint condition conducive to lead poisoning shall not absolve, relieve or discharge any persons chargeable therewith from the obligation and responsibility to discontinue such paint condition conducive to lead poisoning in accordance with the method of discontinuance prescribed therefor in such notice and demand.

§ 1374. Receivership. 1. In the event of failure to comply with an order issued pursuant to this title and containing provision for such application, the officer issuing the order may apply to a court of competent jurisdiction in the county wherein the dwelling is located for an order appointing such officer or his designee receiver of the rents of such dwelling for the purpose of effectuating the provisions of such order.

2. An application for appointment of a receiver hereunder shall be on at least ten days' notice to the owner of the dwelling, effected in the same manner as in an action to foreclose a mortgage. A receiver appointed hereunder shall not have any right superior to those of any mortgagee or lienor of record who has not had at least ten days' notice, by personal service or registered or certified mail, of the application for appointment of a receiver.

3. A receiver appointed hereunder shall have the power to collect the accrued and accruing rents of the dwelling and shall apply such collected rents to costs and expenses incurred in connection with (a) removing, replacing, repainting and covering surfaces of the dwelling necessary to effectuate the provisions of the order of abatement, (b) interim operation and management of the dwelling, (c) administration of

the receivership.

4. As soon as practicable after completion of his duties, the receiver shall render a full accounting to the court and, upon payment over of any surplus moneys to the owner or other persons as the court may approve or direct and upon the order of the court, he shall be relieved of any further responsibility or liability in connection with his receivership.

§ 1375. Enforcement agencies. 1. The commissioner's designee having jurisdiction, county and city commissioners of health and local housing code enforcement agencies designated by the commissioner's designee having jurisdiction or county or city commissioner of health shall have the same authority, powers and duties within their respective jurisdictions as has the commissioner under the provisions of this title.

2. The commissioner or his representative and an official or agency specified in subdivision one of this section may request and shall receive from all public officers, departments and agencies of the state and its political subdivisions such cooperation and assistance as may be necessary or proper in the enforcement of the provisions of this title.

3. Nothing contained in this title shall be construed to alter or abridge any duties and powers now or hereafter existing in the commissioner, county boards of health, city and county commissioners of health, the New York City department of housing preservation and development and the department of health, local boards of health or other public agencies or public officials, or any private party.

§ 1376-a. Sale of consumer products containing lead or cadmium. 1. In the absence of a federal standard for a specific type of product, the commissioner shall establish the maximum quantity of lead or cadmium (and the manner of testing therefor) which may be released from glazed ceramic tableware, crystal, china and other consumer products. Such

maximum quantity shall be based on the best available scientific data and shall insure the safety of the public by reducing its exposure to lead and cadmium to the lowest practicable level. The commissioner may amend such maximum quantity (and the manner of testing therefor) where necessary or appropriate for the safety of the public. Until such maximum quantity of lead or cadmium established by the commissioner is effective, no glazed ceramic tableware shall be offered for sale which releases lead in excess of 7 parts per million, or cadmium in excess of .5 parts per million.

2. The commissioner is hereby empowered to order the recall of or confiscation of glazed ceramic tableware, crystal, china or other consumer products offered for sale which do not meet the standards set forth in or pursuant to this section.

3. The commissioner of health may waive the provisions of this section in whole or in part upon a finding by the commissioner in a particular instance that there is no significant threat to the public health; with respect to miniatures the commissioner shall do so, on terms and conditions he or she shall establish, upon a final judicial or administrative finding that there is no immediate public health threat in that instance.

*** § 1377. State rental registry and proactive inspections to identify lead hazards.** 1. The department shall, in consultation with the division of housing and community renewal, develop a registry for all residential dwellings with two or more units built prior to nineteen hundred eighty which, by virtue of their property class designation, are potentially eligible for rental, lease, let or hiring out, and are located within communities of concern as identified by the department. Such registry shall only include qualifying residential dwellings outside a city with a population of one million people or more. The department shall utilize all available property information to develop the registry including but not limited to information from tax assessment rolls and information from property records in the office in which instruments affecting real property in the county are recorded.

2. The department, or their designee, shall provide written notice to the owners of residential dwellings qualifying for registration in accordance with this section within sixty days of the effectiveness of such registry.

3. Owners of all residential dwellings qualifying for registration in accordance with this section shall certify as free of lead paint hazards, in accordance with subdivision seven of this section and the regulations promulgated thereunder. Inspection certifications must be submitted by the owner to the local health department or their designee for recording in the rental registry by October first of the year the certification is due.

4. The department, or their designee, shall provide owners of qualifying residential dwellings a minimum of two notices prior to the deadline to submit a certification, not including the notification under subdivision two of this section. Such notice shall include information for owners to notify the department or their designee a residential dwelling is not eligible for rental, lease, let or hiring out and are therefore not required to submit a certification under this section.

If an owner fails to submit a certification by the deadline, or incorrectly asserts that they are not required to submit a certification under this section, the department, or their designee, shall provide an additional notice prior to taking any further action.

5. The department shall establish an annual inspection and audit process which shall review at least ten percent of the certification inspections of residential dwellings qualifying for the rental registry. Such process shall include individual inspections and document review to ensure that owners complied with all obligations and responsibilities under this section. Such audits shall be conducted in-person and shall confirm that a residential dwelling is or is not eligible for the rental registry and that the residential dwelling is free of lead paint hazards.

6. The commissioner shall promulgate regulations as needed to administer, coordinate, and enforce this section.

7. The commissioner shall promulgate regulations regarding the inspections required to be completed pursuant to this section as well as the certification of such inspections which shall include, but not be limited to: (a) the frequency of such inspections which shall be no less frequent than every three years; (b) the minimum conditions the residential dwelling must meet for a valid inspection certification; (c) qualifications for inspectors; (d) minimum standards for a standardized form on which the owner of a residential dwelling may self-certify as to a satisfactory inspection, such form shall require such owner to confirm such residential dwelling meets all the requirements of paragraph (b) of this subdivision and may require such owner to submit any documentation deemed necessary by the commissioner, provided, however, such owner shall meet the qualifications pursuant to paragraph (c) of this subdivision; (e) alternative methods of certification, which may include the submission of a valid and active residential occupancy permit for which the minimum conditions required under paragraph (b) of this subdivision were required to be met for such issuance; (f) procedures for false certifications, upon a finding by the department that a self-certified dwelling contains lead hazards; and (g) any other information or requirements deemed necessary by the commissioner to administer, coordinate, and enforce this section.

8. The inspection requirements under this section shall, at a minimum, include visual inspections for deteriorated paint and outdoor soil conditions, as well as the collection of dust wipe samples obtained in accordance with United States Environmental Protection Agency protocols for such procedures.

9. Remediation of lead-based paint hazards must be conducted in compliance with all municipal requirements and specific requirements specified in regulation.

10. A failure to file or filing a false certificate as required under this section shall be subject to civil penalties under section twelve of

this chapter, in addition to any penalties that may apply.

11. The commissioner shall, on or before December thirty-first in each year, beginning the calendar year after the effective date of this section, submit a report to the governor, the temporary president of the senate, and the speaker of the assembly on the activity and implementation of this section. Such report shall include but not be limited to: the number of residential properties qualifying for registration, the number of properties required to submit inspection certifications by October first of such year, the number of inspection certifications submitted by October first of such year, the number of inspections conducted pursuant to the audit process established in subdivision five of this section, the results of the audit process established in subdivision five of this section, and such other information as the commissioner determines. The information provided in the report shall reflect statewide activities in the aggregate and activities for each community of concern.

* NB Repealed November 3, 2028

TITLE ELEVEN

STATE AID: PLANNING FOR CONSTRUCTION OF SOLID WASTE MANAGEMENT FACILITIES

Section 1380. Definitions.

1381. State aid.

1382. Powers and duties of the commissioner.

1383. Powers of municipalities.

§ 1380. Definitions. As used in this title:

1. "Solid waste management facility" means any area or site, structure, facility or equipment used for or in connection with methods including, but not limited to shredding, compression, high-temperature incineration, pyrolization, separation or any other technology for resource recovery, transporting, storing, or the final placement and disposal of solid wastes in a manner satisfactory to the commissioner.

2. "Municipality" means a town, city, county, or village or any designated public agency thereof, or any two or more of the foregoing which are acting jointly in connection with a solid waste management facility, or a public authority.

3. "Commissioner" means the commissioner of environmental conservation of the state of New York.

§ 1381. State aid. 1. The commissioner may in the name of the state make or contract to make, within the limitation of the appropriations therefor, a state grant for payment to any municipality or to two or more municipalities jointly of not more than fifty per cent of the entire cost of the preparation of detailed plans, including consideration of recycling technology, ultimate land use, and environmental impact, for the construction of new solid waste management facilities or the improvement of existing solid waste management facilities, as determined and approved by the commissioner.

2. Payments authorized pursuant to this title shall be made in two apportionments, as follows:

(a) the first payment, not to exceed fifty per cent of the total grant, shall be payable when acceptable detailed plans are approved by the commissioner, and

(b) the balance of the grant shall be payable when construction contracts are awarded, or when construction begins, whichever occurs first.

§ 1382. Powers and duties of the commissioner. In administering and enforcing the provisions of this title, the commissioner shall:

1. make an estimate of funds or appropriations for inclusion annually in the executive budget;

2. receive applications for state aid in such form and containing such

information as he may require;

3. qualify municipalities for state aid and advise them concerning such qualifications;

4. approve detailed plans submitted by the applicant for the construction of solid waste management facilities or for improvement of existing solid waste management facilities where the same are found to be consistent with sound, comprehensive solid waste management planning, take into adequate account the feasibility of a recycling facility to shred, compress, pyrolize, separate or otherwise process the solid waste for resource recovery, the potential resources to be recovered, ultimate land use and are otherwise acceptable to him; provided, however, plans further:

a. describe the components of the solid waste estimated to be generated, by weight or volume;

b. describe the proposed method of transporting to be utilized from its source to the solid waste management facility, and the estimated cost therefor;

c. detail the separation techniques proposed to be utilized at the solid waste management facility; and

d. specify what and where the available markets are for recovered materials within the region covered by the plan, and/or within fifty miles outside the region covered by the plan;

5. approve vouchers for payment of state aid grants;

6. perform such other and further acts and promulgate such rules and regulations as may be necessary, proper or desirable to carry out effectively the provisions of this title.

§ 1383. Powers of municipalities. Any municipality or municipalities

acting jointly may:

1. apply to and contract with the commissioner for state aid pursuant to this title;

2. enter into contracts for consulting engineering services for the preparation of detailed plans for the construction of solid waste management facilities or the improvement of existing solid waste management facilities; provided, however, the contract cost negotiated between the person or firm chosen to perform the consulting engineering services or market research and the applicant for state aid under this title shall be subject to the approval of the commissioner;

3. expend money received from the state pursuant to this title only for purposes consistent therewith.

TITLE XII TOXIC SUBSTANCES

Section 1385. Legislative intent.

1386. Duties of the commissioner.

1387. Contracts.

1388. Powers of the commissioner; emergencies.

1389. Reports.

§ 1385. Legislative intent. Sites formerly operated as landfills to dispose of toxic substances are exposing the citizens of the state to unnecessary hazards, the duration and extent of which is unknown. To develop a plan for the alleviation of these conditions, it is necessary to conduct a study to determine the extent of such hazards. The potential hazard believed to exist at a specific landfill site in the county of Niagara, has precipitated the need for immediate action to authorize the department of health to undertake such study and to conduct a pilot program to evaluate the effect of individual corrective systems in affected residences.

§ 1386. Duties of the commissioner. The commissioner of health shall conduct a study of both the long and the short term effects of health hazards associated with exposure to toxic substances emanating from certain landfills.

§ 1387. Contracts. The commissioner of health is authorized to enter into contracts and agreements with individuals, corporations and municipalities to perform the study herein directed to alleviate the specific hazard to which the general public or members thereto may be exposed as the result of toxic substances emanating from landfills.

§ 1388. Powers of the commissioner; emergencies. In case of great and imminent peril to the health of the general public from such hazards as may be identified as resulting from exposure to toxic substances emanating from landfills, the commissioner may declare the existence of an emergency and take such measures and do such acts as he may deem reasonably necessary and proper for the preservation and protection of the public health.

§ 1389. Reports. The commissioner of health shall make an initial report to the governor and the legislature on or before September fifteenth, nineteen hundred seventy-eight of his progress and a further report to the governor and the legislature on or before April first, nineteen hundred eighty-one.

TITLE XII-A

INACTIVE HAZARDOUS WASTE DISPOSAL SITES

Section 1389-a. Definitions.

1389-b. Powers of the commissioner.

1389-c. Rules and regulations.

1389-d. New use of sites.

1389-e. Liability exemptions and defenses.

§ 1389-a. Definitions. 1. "Hazardous waste" means hazardous waste as defined in section 27-1301 of the environmental conservation law.

2. "Inactive hazardous waste disposal site" means an inactive hazardous waste disposal site as that term is defined in section 27-1301 of the environmental conservation law.

3. "Inactive hazardous waste disposal site remedial program" means an inactive hazardous waste disposal site remedial program as that term is defined in section 27-1301 of the environmental conservation law.

4. "Person" means an individual, trust, firm, joint venture, joint stock company, corporation, limited liability company, partnership, association, state, municipality, commission, political subdivision of a state, public benefit corporation, or any interstate body. Provided, however for the purposes of this title, a person shall not include a person as defined in section one thousand three hundred eighty-nine-e of this title.

5. "Waste" shall have the same meaning as set forth in section 27-1301 of the environmental conservation law.

§ 1389-b. Powers of the commissioner. 1. (a) The department shall be responsible for assessing (i) serious health problems at and in the immediate vicinity of inactive hazardous waste disposal sites and (ii) any health problems deemed by the department to be related to conditions at such sites.

(b) Section eight of the court of claims act or any other provision of law to the contrary notwithstanding, the state shall be immune from liability and action with respect to any act or omission done in the discharge of the department's responsibility pursuant to this title; provided, however, that this subdivision shall not limit any liability which may otherwise exist for unlawful, willful or malicious acts or omissions on the part of the state, state agencies, their officers,

employees or agents, or for ownership or responsibility for the disposal of hazardous waste, including the cost of cleanup, pursuant to this section or section 27-1313 of the environmental conservation law.

2. Whenever there is a condition dangerous to life or health resulting from an inactive hazardous waste disposal site, the commissioner shall immediately declare the existence of such condition. After the issuance of any such declaration and throughout the time period during which such a declaration is effective, the department shall be responsible for (a) monitoring such inactive hazardous waste disposal sites, (b) approving proposed inactive hazardous waste disposal site remedial programs for such sites and (c) certifying the completion of inactive hazardous waste disposal site remedial programs for such sites.

3. (a) Whenever the commissioner has issued such a declaration and throughout the time period during which such a declaration is effective, the commissioner may request the commissioner of environmental conservation pursuant to paragraph (b) of subdivision five of this section and within the funds available to the department of environmental conservation to develop an inactive hazardous waste disposal site remedial program for such site and/or, in addition to any other powers he may have, order the owner of such site and/or any person responsible for the disposal of hazardous wastes at such site (i) to develop an inactive hazardous waste disposal site remedial program for such site subject to the approval of the department and (ii) to implement such program within reasonable time limits specified in the order. Such order shall supersede any order issued by the commissioner of environmental conservation pursuant to section 27-1313 of the environmental conservation law.

(b) Whenever the commissioner has issued such a declaration and further finds that it would be prejudicial to the public interest to delay action until an opportunity for a hearing can be provided pursuant to this title, the department may request, pursuant to paragraph c of subdivision five of this section and within the funds available to the department of environmental conservation, the department of environmental conservation to develop and implement an inactive hazardous waste disposal site remedial program for such site. The

finding required pursuant to this paragraph may be made by the commissioner on an ex parte basis subject to judicial review.

4. Any order issued pursuant to subdivision three of this section shall be issued only after notice and the opportunity for hearing is provided to the persons who may be the subject of such order. The commissioner shall determine which persons are responsible pursuant to said subdivision according to applicable principles of statutory or common law liability. Such persons shall be entitled to raise any statutory or common law defenses at any such hearing and such defenses shall have the same force and effect at such hearings as they would have in a court of law. In the event a hearing is held, no order shall be issued by the commissioner under subdivision three of this section until a final decision has been rendered. Any such order shall be reviewable pursuant to article seventy-eight of the civil practice law and rules within thirty days after service of said order. The commissioner may request the participation of the attorney general in such hearings.

5. (a) Whenever a person ordered to eliminate a condition dangerous to life or health has failed to do so within the time specified in the order, the department of environmental conservation shall develop and implement or cause to be implemented, pursuant to a memorandum of understanding between the department and the department of environmental conservation, an inactive hazardous waste disposal site remedial program for such site. The expense of developing and implementing such remedial program by the department, the department of environmental conservation or any other state agency shall be paid by the person to whom the order was issued.

(b) In the event that the commissioner has issued a declaration that hazardous wastes at a site constitute a condition dangerous to life or health, but after a reasonable attempt to determine who may be responsible is either unable to determine who may be responsible, or is unable to locate a person who may be responsible, the department of environmental conservation may develop and implement an inactive hazardous waste disposal site remedial program for such site. The commissioner shall make every effort, in accordance with the requirements for notice, hearing and review provided for in this title,

to secure appropriate relief from the owner of such site and/or any person responsible for the disposal of hazardous wastes at such site, including, but not limited to, development and implementation of an inactive hazardous waste disposal site remedial program, payment of the cost of such a program, recovery of any reasonable expenses incurred by the state, money damages and penalties.

(c) Whenever the commissioner has made a declaration and finding pursuant to paragraph (b) of subdivision three of this section the department may request the department of environmental conservation to develop and implement an inactive hazardous waste disposal site remedial program to contain, alleviate or end the threat to life or health. The commissioner shall make every effort, in accordance with the requirements for notice, hearing and review provided for in this title, to secure appropriate relief from the owner or operator of such site and any person responsible for the disposal of hazardous wastes at such site, including but not limited to, development and implementation of an inactive hazardous waste disposal site remedial program, payment of the cost of such a program, recovery of any reasonable expenses incurred by the state, money damages and penalties.

6. Nothing contained within this section shall be construed as impairing or in any manner affecting the right or jurisdiction of the attorney general to seek appropriate relief pursuant to his statutory or common law authority.

7. If the person failing to comply with such order to eliminate a condition dangerous to life or health is a municipality, commission or political subdivision of the state, the comptroller shall, upon certification by the department subject to the approval of the director of the division of the budget of the expense of any action taken by the department, the department of environmental conservation or any other state agency pursuant to subdivision five of this section and upon notification to the affected person, deduct and withhold from the next succeeding allotments, payments or apportionments of local assistance aid, other than education aid, to such municipality, commission or political subdivision of the state an amount or amounts equal to the amount expended by the department, the department of environmental

conservation or any other state agency and not paid. Prior to such approval by the director of the division of the budget, the director shall (a) develop a schedule of deductions and withholdings that will ensure the continuity of essential services by such municipality, commission or political subdivision of the state and (b) give thirty days written notice of such deductions and withholdings to the speaker and minority leader of the assembly, the majority and minority leaders of the senate and the chairmen and ranking minority members of the senate finance committee and the assembly ways and means committee. Such deductions or withholdings will in no case take effect before one full fiscal year of the affected person after the date of such approval by the director of the division of the budget shall have elapsed. The state, by virtue of such deductions or withholdings, shall not be obligated to pay any additional or increased allotments, payments or apportionments of state aid. Allotments, payments or apportionments withheld pursuant to this subdivision shall be credited to the general fund of the state.

8. Moneys for actions taken or to be taken by the department, the department of environmental conservation or any other state agency in connection with the elimination of conditions dangerous to life or health pursuant to subdivision five of this section, including any inspection or sampling of wastes, soils, air, surface water and groundwater done upon behalf of a state agency whether or not such action is taken prior to the issuance of a declaration pursuant to subdivision two of this section, shall be payable directly to such agencies from the hazardous waste remedial fund pursuant to section ninety-seven-b of the state finance law.

§ 1389-c. Rules and regulations. The department shall have the power to make rules and regulations necessary and appropriate to carry out the purposes of this title. Any such regulations shall include provisions which establish the procedures for a hearing, pursuant to subdivision four of section thirteen hundred eighty-nine-b of this article. Such provision shall ensure a division of functions between the commissioner, the staff who present the case and any hearing officers appointed.

§ 1389-d. New use of sites. Subsequent to the adoption of regulations by the department of environmental conservation pursuant to section 27-1317 of the environmental conservation law, no person may substantially change the manner in which an inactive hazardous waste disposal site on the registry prepared and maintained by the department of environmental conservation pursuant to section 27-1305 of the environmental conservation law is used, without notifying the department and, pursuant to section 27-1317 of the environmental conservation law, the department of environmental conservation. A substantial change of use shall be defined in rules and regulations adopted by the department of environmental conservation and shall include, but not be limited to, the erection of a building or other structure on such site, the paving of such site for use as a roadway or parking lot, and the creation of a park or other public or private recreational facility on such site. Such notice shall be in writing, addressed to the commissioner and the commissioner of environmental conservation and shall include a brief description of the proposed change of use. Such notice shall be submitted at least sixty days before any physical alteration of the land or construction shall occur or, in the event any alteration or construction is not required to initiate such change of use, at least sixty days before any change of use.

Subsequent to the adoption of regulations by the department of environmental conservation pursuant to section 27-1317 of the environmental conservation law, no person may substantially change the manner in which an inactive hazardous waste disposal site, for which a declaration has been issued by the commissioner pursuant to subdivision two of section one thousand three hundred eighty-nine-b of this title, is used without the written approval of the commissioner. The commissioner shall not approve such change of use if such new use will expose persons to a significantly increased danger to life or health.

§ 1389-e. Liability exemptions and defenses. 1. Lender exemption. (a) For purposes of this title no lender shall incur any liability from any

statutory claims of the state as an owner or operator of a site, or a person responsible for the disposal of a hazardous waste at such site, provided such lender, without participating in the management of such site, holds indicia of ownership primarily to protect the lender's security interest in the site or, if such lender did not participate in the management of such site prior to a foreclosure on such site, notwithstanding that such lender:

(1) forecloses on such site; and

(2) after foreclosure, sells, releases (in the case of a lease finance transaction), or liquidates such site, maintains business activities, winds up operations, or takes any other measure to preserve, protect or prepare such site prior to sale or disposition; provided, however, that such lender shall take actions to sell, release (in the case of a lease finance transaction), or otherwise divest itself of such site at the earliest practicable, commercially reasonable time, on commercially reasonable terms, taking into account market conditions and legal and regulatory requirements.

(b) This exemption shall not apply to any lender that has caused or contributed to the release or threatened release of a hazardous waste from or onto the site, or to any lender that generated, transported, or disposed of, arranged for, or that caused the generation, transportation, or disposal of hazardous waste from or onto such site.

(c) For purposes of this section:

(1) The term "participating in management" means actually participating in the management or operational affairs of a site and does not include merely having the capacity to influence, or the unexercised right to control, site operations.

(i) A lender who holds indicia of ownership primarily to protect a security interest in such site shall be considered to participate in management only if, while the borrower is in possession of such site encumbered by the security interest, the lender:

(A) exercises decision making control over the environmental compliance related to such site, such that the lender has undertaken responsibility for the hazardous waste handling or disposal practices related to such site; or

(B) exercises control at a level comparable to that of a manager of such site, such that the lender has assumed or manifested

responsibility:

(I) for the overall management of such site encompassing day-to-day decision making with respect to environmental compliance; or

(II) over all or substantially all of the operational functions, excluding financial or administrative functions, of such site other than the function of environmental compliance.

(ii) The term "participate in management" does not include:

(A) Performing an act or failing to act prior to the time at which a security interest is created in a site;

(B) Holding a security interest or abandoning or releasing a security interest;

(C) Including in the terms of an extension of credit, or in a contract or security agreement relating to such extension, a covenant, warranty, or other term or condition that relates to environmental compliance;

(D) Monitoring or enforcing the terms and conditions of the extension of credit or security interest;

(E) Monitoring or undertaking one or more inspections of such site;

(F) Requiring a response action or other lawful means of addressing the release or threatened release of a hazardous waste in connection with such site prior to, during, or on the expiration of the term of the extension of credit;

(G) Providing financial or other advice or counseling in an effort to mitigate, prevent, or cure default or diminution in the value of such site;

(H) Restructuring, renegotiating, or otherwise agreeing to alter the terms and conditions of the extension of credit or security interest, exercising forbearance;

(I) Exercising other remedies that may be available under applicable law for the breach of a term or condition of the extension of credit or security agreement; or

(J) Conducting a response action under 42 U.S.C. Section 9607(d) or under the direction of an on-scene coordinator appointed under the national contingency plan if the actions do not rise to the level of participating in management within the meaning of this subparagraph.

(2) The term "extension of credit" includes a lease finance transaction:

(i) In which the lessor does not initially select the leased site and

does not during the lease term control the daily operations or maintenance of such site; or

(ii) That conforms with regulations issued by the appropriate federal banking agency or the appropriate state bank supervisor (as those terms are defined in section 3 of the federal deposit insurance act (12 U.S.C. 1813)) or with regulations issued by the national credit union administration board, as appropriate.

(3) The term "financial or administrative function" includes a function such as that of a credit manager, accounts payable officer, accounts receivable officer, personnel manager, comptroller, or chief financial officer, or a similar function.

(4) The terms "foreclosure" and "foreclose" mean, respectively, acquiring and to acquire, a site through:

(i) Purchase at sale under a judgment or decree, power of sale, or nonjudicial foreclosure sale;

(ii) A deed in lieu of foreclosure or similar conveyance from a trustee;

(iii) Repossession if such site was security for an extension of credit previously contracted;

(iv) Conveyance pursuant to an extension of credit previously contracted, including the termination of a lease agreement; or

(v) Any other formal or informal manner by which the lender acquires, for subsequent disposition, title to or possession of a site in order to protect the lender's security interest.

(5) The term "lender" means:

(i) An insured depository institution as defined in section 3 of the federal deposit insurance act (12 U.S.C. 1813);

(ii) An insured credit union as defined in section 101 of the federal credit union act (12 U.S.C. 1752);

(iii) A bank or association chartered under the farm credit act of 1971 (12 U.S.C. 2001 et seq.);

(iv) A leasing or trust company that is an affiliate of an insured depository institution;

(v) Any person, including a successor or assignee of any such person, that makes a bona fide extension of credit to or takes or acquires a security interest from a nonaffiliated person;

(vi) The federal national mortgage association, the federal home loan

mortgage corporation, the federal agricultural mortgage corporation, or any other entity that in a bona fide manner buys or sells loans or interests in loans;

(vii) A person that insures or guarantees against a default in the repayment of an extension of credit, or acts as a surety with respect to an extension of credit, to a nonaffiliated person; and

(viii) A person that provides title insurance and that acquires a site as a result of assignment or conveyance in the course of underwriting claims and claims settlement.

(6) The term "operational function" includes a function such as that of a site or plant manager, operations manager, chief operating officer, or chief executive officer.

(7) The term "security interest" includes a right under a mortgage, deed of trust, assignment, judgment, lien, pledge, security agreement, factoring agreement, or lease, and any other right accruing to a person to secure the repayment of money, the performance of a duty, or any other obligation by a nonaffiliated person.

2. Municipal exemption. (a) For the purposes of this title no public corporation shall incur any liability from any statutory claims of the state as an owner or operator of a site, or a person responsible for the disposal of a hazardous waste at such site, if such public corporation acquired such site involuntarily, and such public corporation retained such site without participating in the development of such site.

(b) This exemption shall not apply to any public corporation that has caused or contributed to the release or threatened release of a hazardous waste from or onto the site, or to any public corporation that generated, transported, or disposed of, arranged for, or that caused the generation, transportation, or disposal of hazardous waste, from or onto the site.

(c) When used in this section:

(1) "Public corporation" means a public corporation as defined in section sixty-five of the general construction law, a local public authority, supervisory district, improvement district within a county, city, town, or village, or Indian nation or tribe recognized by the state or the United States with a reservation wholly or partly within the boundaries of New York state, or any combination thereof.

(2) "Involuntary acquisition of ownership or control" includes but is not limited to the following:

(i) Acquisitions by a public corporation in its sovereign capacity, including but not limited to acquisitions pursuant to abandonment proceedings or bequest;

(ii) Acquisitions by a public corporation, or its agent, acting as a conservator or receiver pursuant to a clear and direct statutory mandate or regulatory authority;

(iii) Acquisitions of assets through foreclosure and its equivalents, or otherwise, by a public corporation in the course of administering a loan, loan guarantee, tax lien, or tax forbearance agreement, or loan insurance program; or

(iv) Acquisitions by a public corporation pursuant to seizure, injunction, condemnation, or forfeiture authority; provided that such ownership or control is not retained primarily for investment purposes.

(d) For the purpose of this section, the terms "foreclosure" and "foreclose" mean, respectively, acquiring or to acquire a brownfield site through:

(1) purchase at sale under a judgment or decree, power of sale, or non-judicial foreclosure sale;

(2) a deed in lieu of foreclosure, or similar conveyance, or abandonment from a person or trustee;

(3) conveyance pursuant to an extension of credit or tax forbearance previously contracted; or

(4) any other formal or informal manner by which a person acquires, for subsequent disposition, title to or possession of a site in order to protect the security interest of the public corporation or lender.

(e) "Participating in development" means the carrying out, or causing or permitting the carrying out, of any above-grade improvements to the site or any other environmental investigation or remediation, except for those improvements which are part of a site remedial program pursuant to this article or in furtherance of site safety, such as fencing or lighting, but does not include licensing, regulatory oversight, or the mere capacity to regulate or influence, or the unexercised right to control the operation of the property. For purposes of this section, participating in development does not include:

(1) having the capacity to influence management of a site;

(2) having the unexercised right to control or to regulate the site or operations thereof;

(3) holding, abandoning, or releasing a security interest or tax lien on such site;

(4) including a condition relating to environmental compliance in a contract, permit, license, or security agreement;

(5) monitoring or enforcing the terms and conditions of an agreement or tax forbearance agreement;

(6) monitoring or undertaking one or more inspections of a site including, but not limited to, boring test wells;

(7) exercising other remedies available under applicable laws;

(8) licensing, permitting, or granting permits, certificates of occupancy and variances as allowed by law and/or regulation;

(9) applying for or participating in federal or state statutory programs or benefits; or

(10) declining to take any of the actions described in subparagraphs one through nine of this paragraph.

(f) Any public corporation that has taken possession of a site shall notify the department of any release of hazardous waste within ten days of obtaining actual knowledge of such release, unless a shorter notice period is required under any other provision of law, in which case the shorter notice period controls. Failure to notify the department within the ten day or shorter notification period shall result in the loss of the exemption set forth in this section.

3. Fiduciary liability cap. For the purpose of this title, liability on the part of a fiduciary shall not exceed the assets held in the fiduciary capacity if such person is not liable independently of such person's ownership as a fiduciary or actions taken in a fiduciary capacity including, but not limited to, the fiduciary's negligently causing or contributing to the release or threatened release of hazardous waste at such site.

(a) For purposes of this subdivision:

(1) the term "fiduciary" means a person acting for the benefit of another party as a bona fide trustee; executor; administrator; custodian; guardian of estates or guardian ad litem; receiver; conservator; committee of estates of incapacitated person; personal

representative; trustee (including a successor to a trustee) under an indenture agreement, trust agreement, lease, or similar financing agreement, for debt securities, certificates of interest or certificates of participation in debt securities, or other forms of indebtedness as to which the trustee is not, in the capacity of trustee, the lender; or representative in any other capacity that the department, after providing public notice, determines to be similar to the various capacities previously described in this paragraph; and does not include either a person that is acting as a fiduciary with respect to a trust or other fiduciary estate that was organized for the primary purpose of, or is engaged in, actively carrying on a trade or business for profit, unless the trust or other fiduciary estate was created as part of, or to facilitate, one or more estate plans or because of the incapacity of a natural person or a person that acquires ownership or control of a property with the objective purpose of avoiding liability of the person or any other person.

(2) the term "fiduciary capacity" means the capacity of a person in holding title to a property, or otherwise having control of or an interest in a property, pursuant to the exercise of the responsibilities of the person as a fiduciary.

(b) Nothing in this subdivision affects the rights or immunities or other defenses that are available under law that are applicable to a person subject to this section; or creates any liability for a person or a private right of action against a fiduciary or any other person.

(c) Nothing in this subdivision applies to a person if that person acts in a capacity other than that of a fiduciary or in a beneficiary capacity and in that capacity, directly or indirectly, benefits from a trust or fiduciary relationship; or is a beneficiary and a fiduciary with respect to the same fiduciary estate and, as a fiduciary, receives benefits that exceed customary or reasonable compensation, and incidental benefits, permitted under other applicable law.

(d) This subdivision does not preclude a claim under this chapter against the assets of the estate or trust administered by the fiduciary; or a nonemployee agent or independent contractor retained by a fiduciary.

4. Affirmative defenses. (a) There shall be no liability under this

title for a person otherwise liable who can establish by a preponderance of the evidence that the significant threat to the environment attributable to hazardous waste disposed at an inactive hazardous waste disposal site was caused solely by: (1) an act of God; (2) an act of war; or (3) an act or omission of a third party other than an employee or agent of such person, or than one whose act or omission occurs in connection with a contractual relationship existing directly or indirectly with such person (except where the sole contractual arrangement arises from a published tariff and acceptance for carriage by a common carrier or rail), if such person establishes by a preponderance of the evidence that: (i) such person exercised due care with respect to the hazardous waste concerned, taking into consideration the characteristics of such hazardous waste, in light of all relevant facts and circumstances, and (ii) took precautions against foreseeable acts or omissions of any such third party and the consequences that could foreseeably result from such acts or omissions; or any combination of them.

(b) For purposes of this section, (1) the term "act of God" means an unanticipated grave natural disaster or other natural phenomenon of an exceptional, inevitable, and irresistible character, the effects of which could not have been prevented or avoided by the exercise of due care or foresight, (2) the term "contractual relationship" includes, but is not limited to, land contracts, deeds, or other instruments transferring title or possession, unless the real property on which the site concerned is located was acquired by such person after the disposal or placement of the hazardous waste on, in, or at such site, and such person establishes one or more of the circumstances described in clause (i), (ii), or (iii) of this subparagraph by a preponderance of the evidence:

(i) At the time such person acquired the site, such person did not know and had no reason to know that any hazardous waste which is the subject of the significant threat determination was disposed of on, in, or at the site; or

(ii) Such person is a government entity which acquired the site by escheat, or through any other involuntary transfer or acquisition or through the exercise of eminent domain authority by purchase or condemnation; or

(iii) Such person acquired the site by inheritance or bequest. In addition to establishing the foregoing, the person must establish that he or she has satisfied the requirements of clauses (i) and (ii) of subparagraph three of paragraph (a) of this subdivision, provides full cooperation, assistance, and site access to the persons that are authorized to conduct remedial actions at the site (including the cooperation and access necessary for the installation, integrity, operation, and maintenance of any complete or partial remedial action at the site), is in compliance with any land use restrictions established or relied on in connection with the remedial action at a site, and does not impede the effectiveness or integrity of any institutional and/or engineering control employed at the site in connection with a remedial action.

(c)(1) To establish that the person had no reason to know of the matter described in clause (i) of subparagraph two of paragraph (b) of this subdivision, the person must demonstrate to a court that:

(i) on or before the date on which the person acquired the site, the person carried out all appropriate inquiries, as provided in subparagraphs two and four of this paragraph, into the previous ownership and uses of the site in accordance with generally accepted good commercial and customary standards and practices; and

(ii) the person took reasonable steps to:

(A) stop any continuing release;

(B) prevent any threatened future release; and

(C) prevent or limit any human, environmental, or natural resource exposure to any previously released hazardous waste.

(2) Not later than one year after the effective date of this section, the commissioner shall by regulation establish standards and practices for the purpose of satisfying the requirement to carry out all appropriate inquiries under subparagraph one of this paragraph.

(3) In promulgating regulations that establish the standards and practices referred to in subparagraph two of this paragraph, the commissioner shall include each of the following:

(i) the results of an inquiry by an environmental professional;

(ii) interviews with past and present owners, operators, and occupants of the site for the purpose of gathering information regarding the potential for contamination at the site;

(iii) reviews of historical sources, such as chain of title documents, aerial photographs, building department records, and land use records, to determine previous uses and occupancies of the real property since the property was first developed;

(iv) searches for recorded environmental cleanup liens against the site that are filed under federal, state, or local law;

(v) reviews of federal, state, and local government records, waste disposal records, underground storage tank records, and hazardous waste handling, generation, treatment, disposal, and spill records, concerning contamination at or near the site;

(vi) visual inspections of the site and of adjoining properties;

(vii) specialized knowledge or experience on the part of the person;

(viii) the relationship of the purchase price to the value of the property, if the property was not contaminated;

(ix) commonly known or reasonably ascertainable information about the property;

(x) the degree of obviousness of the presence or likely presence of contamination at the property, and the ability to detect the contamination by appropriate investigation.

(4)(i) With respect to property purchased before May thirty-first, nineteen hundred ninety-seven, in making a determination with respect to a person described in subparagraph one of this paragraph a court shall take into account:

(A) any specialized knowledge or experience on the part of the person;

(B) the relationship of the purchase price to the value of the property, if the property was not contaminated;

(C) commonly known or reasonably ascertainable information about the property;

(D) the obviousness of the presence or likely presence of contamination at the property; and

(E) the ability of the person to detect the contamination by appropriate inspection.

(ii) With respect to property purchased on or after May thirty-first, nineteen hundred ninety-seven, and until the commissioner of environmental conservation promulgates the regulations described in subparagraph two of this paragraph, the procedures of the American Society for Testing and Materials, including the document known as

"Standard E1527-97", entitled 'Standard Practice for Environmental Site Assessment: Phase 1 Environmental Site Assessment Process', shall satisfy the requirements in subparagraph one of this paragraph.

(5) In the case of property for residential use or other similar use purchased by a nongovernmental or noncommercial entity, a site inspection and title search that reveal no basis for further investigation shall be considered to satisfy the requirements of this subparagraph.

(d) Nothing in this subdivision shall diminish the liability of any previous owner or operator of the site who would otherwise be liable under this title. Notwithstanding this subdivision, if such person obtained actual knowledge of the release or threatened release of a hazardous waste at the site when such person owned the site and then subsequently transferred ownership of the site to another person without disclosing such knowledge, such person shall be treated as a person responsible for the disposal of hazardous waste at the site, and no defense under this subdivision shall be available to such person. Nothing in this subdivision shall affect the liability under this section of a person who, by any act or omission, caused or contributed to the release or threatened release of a hazardous waste which is the subject of such proceeding relating to such site.

TITLE XIII

STORAGE, TREATMENT AND DISPOSAL OF REGULATED MEDICAL WASTE

Section 1389-aa. Definitions.

1389-bb. Requirements for generators of regulated medical waste.

1389-cc. Storage and containment of regulated medical waste.

1389-dd. Treatment and disposal of regulated medical waste.

1389-ee. Transfer of regulated medical waste to off-site
treatment and disposal facilities.

1389-ff. Rules and regulations.

1389-gg. Violations of title thirteen.

§ 1389-aa. Definitions. 1. "Regulated medical waste" shall mean any of the following waste which is generated in the diagnosis, treatment or

immunization of human beings or animals, in research pertaining thereto, or in production and testing of biologicals, provided, however, that "regulated medical waste" shall not include any hazardous waste identified or listed pursuant to section 27-0903 of the environmental conservation law, or any household waste as defined in regulations promulgated under such section.

(a) Cultures and stocks. This waste shall include cultures and stocks of agents infectious to humans, and associated biologicals, cultures from medical or pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live or attenuated vaccines, or culture dishes and devices used to transfer, inoculate or mix cultures.

(b) Human pathological wastes. This waste shall include tissue, organs, and body parts (except teeth and the contiguous structures of bone and gum), body fluids that are removed during surgery, autopsy, or other medical procedures, or specimens of body fluids and their containers, and discarded material saturated with such body fluids other than urine, provided that the commissioner, by duly promulgated regulation, may exclude such discarded material saturated with body fluids from this definition if the commissioner finds that it does not pose a significant risk to public health. This waste shall not include urine or fecal materials submitted for other than diagnosis of infectious diseases.

(c) Human blood and blood products. This waste shall include: (i) discarded waste human blood, discarded blood components (e.g. serum and plasma) containers with free flowing blood or blood components or discarded saturated material containing free flowing blood or blood components; and (ii) materials saturated with blood or blood products provided that the commissioner, by duly promulgated regulation, may exclude such material saturated with blood or blood products from this definition if the commissioner finds that it does not pose a significant risk to public health.

(d) Sharps. This waste shall include but not be limited to discarded unused sharps and sharps used in animal or human patient care, medical research, or clinical or pharmaceutical laboratories, hypodermic, intravenous, or other medical needles, hypodermic or intravenous syringes to which a needle or other sharp is still attached, Pasteur

pipettes, scalpel blades, or blood vials. This waste shall include, but not be limited to, other types of broken or unbroken glass (including slides and cover slips) in contact with infectious agents. This waste shall not include those parts of syringes from which sharps are specifically designed to be easily removed and from which sharps have actually been removed, and which are intended for recycling or other disposal, so long as such syringes have not come in contact with infectious agents.

(e) Animal waste. This waste shall mean discarded materials, including carcasses, body parts, body fluids, blood, or bedding originating from animals known to be contaminated with infectious agents or from animals inoculated during research, production of biologicals, or pharmaceutical testing with infectious agents.

(f) Any other waste material containing infectious agents designated by the commissioner as regulated medical waste.

2. "Storage" shall mean the containment of regulated medical waste in such a manner as not to constitute disposal of such waste.

3. "Transport" shall mean the movement of regulated medical waste from the point of generation to any intermediate points and finally to the point of ultimate disposal.

4. "Treatment" shall mean any method, technique or process designed to change the character or composition of any regulated medical waste so as to either neutralize such waste or to render such waste not infectious as approved by the commissioner pursuant to section thirteen hundred eighty-nine-dd of this title.

5. "Infectious agents" shall mean any organisms that cause disease or an adverse health impact to humans, except that the commissioner may prescribe by regulation additional infectious agents as may be necessary to protect human health and the environment.

§ 1389-bb. Requirements for generators of regulated medical waste. 1. All the requirements of this title shall apply to hospitals as defined

in subdivision one of section twenty-eight hundred one of this chapter and to residential health care facilities as defined in subdivision three of section twenty-eight hundred one of this chapter and clinical laboratories as defined in section five hundred seventy-one of this chapter.

2. The commissioner shall promulgate regulations establishing standards which shall be applicable to generators of regulated medical waste, as may be necessary to protect human health and the environment. Such standards shall include, but need not be limited to, requirements respecting:

(a) Recordkeeping practices that accurately identify the quantities of such regulated medical waste produced and the disposition thereof;

(b) Compliance with the marking, labeling and packaging requirements pursuant to section thirteen hundred eighty-nine-cc of this title;

(c) Compliance with the tracking system pursuant to section 27-1504 of the environmental conservation law; and

(d) Submission of an annual report to the commissioner of environmental conservation, and additional reports at such times as the said commissioner deems necessary, on such forms as the said commissioner shall prescribe, respecting the quantities of regulated medical waste produced during a specified time period, and the disposition thereof.

§ 1389-cc. Storage and containment of regulated medical waste. 1. Containment of regulated medical waste shall be in a manner and location which affords protection from the environment and limits exposure to the public.

2. Regulated medical waste shall be separated from other waste as soon as practicable in the generator's facility.

3. Unless otherwise approved by the department, regulated medical waste shall be contained at the producing facility only for such periods and under such conditions pursuant to rules and regulations adopted in furtherance of this title.

4. Containment of regulated medical waste shall be separate from other wastes. Containers used for the containment of regulated medical waste shall be marked prominently on the containers with the universal warning sign or the word "biohazard".

5. Regulated medical waste, except for discarded sharps, shall be contained in bags which are impervious to moisture and have a strength sufficient to resist ripping, tearing or bursting under normal conditions of usage and of handling. The bags shall be secured so as to prevent leakage during storage, handling or transport. All bags used for containment and disposal of regulated medical wastes shall be red in color.

6. All discarded sharps shall be contained for disposal in leakproof, rigid, puncture-resistant containers which are secured to preclude loss of the contents. Such containers shall be red in color or shall be conspicuously labeled with the word "infectious" or the words "regulated medical waste".

7. Before regulated medical waste is transported from the generating facility, regulated medical waste contained in disposable containers shall be placed for storage or handling in disposable or reusable pails, cartons, drums, dumpsters or portable bins. The containment system shall be leakproof, have tight-fitting covers and be kept clean and in good repair. The containers may be of any color and shall be conspicuously labeled with the word "infectious" or the words "regulated medical waste".

8. Reusable containers for regulated medical waste shall be thoroughly washed and decontaminated each time they are emptied unless the surfaces of the containers have been completely protected from contamination by disposable liners, bags or other devices removed with the waste.

9. Reusable pails, drums, dumpsters or bins used for containment of regulated medical waste shall not be used for containment of waste to be disposed of as other wastes or for other purposes except after being

decontaminated.

10. Trash chutes shall not be used to transfer regulated medical waste between locations where it is contained.

§ 1389-dd. Treatment and disposal of regulated medical waste. 1. Treatment or disposal of regulated medical waste shall be by one of the following methods:

(a) By incineration in a regulated medical waste incineration facility approved and under permit pursuant to article nineteen of the environmental conservation law, which provides complete combustion of the waste to carbonized or mineralized ash. Regulated medical waste so combusted shall be disposable as nonhazardous waste provided it is not an otherwise hazardous waste as defined in the regulations promulgated under section 27-0903 of the environmental conservation law.

(b) By discharge to sewerage system if the waste is liquid or semiliquid, except as specifically prohibited by the commissioner of health.

(c) By decontamination by autoclaving, or by other technique approved by the department, so as to render the waste noninfectious. Regulated medical waste so treated shall be disposed of as solid waste provided it does not otherwise meet the definition of hazardous waste as defined in the regulations promulgated under section 27-0903 of the environmental conservation law or the regulations promulgated thereunder, and is accompanied by a certificate, in a form prescribed by the commissioner, which evidences such treatment.

(d) By other method approved by the commissioner.

2. Regulated medical waste shall not be disposed of by burial at a landfill disposal facility, unless treated in accordance with subdivision one of this section. All sharps must be rendered unrecognizable prior to disposal.

3. The commissioner, in consultation with the commissioner of environmental conservation, shall develop a limited number of cooperative pilot projects to promote the safe handling, treatment and

disposal of regulated medical waste generated in private residences, including the establishment of guidelines for safe transport and handling of such waste prior to disposal. Such pilot projects shall be limited to a maximum of four municipalities throughout the state, and may vary in scope from single-facility to multi-facility projects. Nothing in this subdivision shall be construed as imposing any new requirements on generators of regulated medical waste. The commissioner shall give due consideration to the experience of the pilot projects in developing rules and regulations authorized in subdivision four of this section. Any moneys allocated by any government or organization to the department of health or the department of environmental conservation for purposes of establishing such pilot projects are hereby authorized for appropriation pursuant to this subdivision.

4. Sharps, including needles, syringes and lancets, originating from a private residence, may be delivered for disposal to a general hospital, as defined in subdivision ten of section twenty-eight hundred one of this chapter, or a residential health care facility, as defined in subdivision three of section twenty-eight hundred one of this chapter. Sharps, including needles, syringes and lancets returned pursuant to this section must be accepted by the hospital or residential health care facility on the condition that the needles, syringes and lancets have been deposited in an approved puncture proof container by the generator. The hospital or residential health care facility receiving such contained sharps must dispose of sharps in accordance with this section. The commissioner shall promulgate rules and regulations establishing guidelines for safe transport and handling of such sharps, including the approval of puncture proof containers for sharps.

§ 1389-ee. Transfer of regulated medical waste to off-site treatment and disposal facilities. 1. Any generator of regulated medical waste shall transfer custody of the waste only to a transporter who is permitted as a regulated medical waste transporter by the department of environmental conservation.

2. Regulated medical waste shall be transported to an off-site

treatment or disposal facility in a leakproof, fully enclosed container or vehicle compartment.

3. Regulated medical waste shall not be transported in the same vehicle with other waste unless the regulated medical waste is separately contained in rigid reusable containers or kept separate by barriers from other waste, or unless all of the waste is to be treated or disposed of as regulated medical waste in accordance with the requirements of this title.

§ 1389-ff. Rules and regulations. The commissioner shall promulgate rules and regulations in conformity with the standards for generators of regulated medical waste, and the storage, containment, treatment and disposal of regulated medical waste found in this title. Nothing in this title shall authorize the commissioner to adopt or amend any rule or regulation in a manner inconsistent with the provisions of title fifteen of article twenty-seven of the environmental conservation law.

§ 1389-gg. Violations of title thirteen. 1. Notwithstanding any other provision of this chapter, any person who violates any of the provisions of, or who fails to perform any duty imposed by this title or any rule or regulation promulgated pursuant thereto, or any term or condition of any certificate or permit issued pursuant thereto, or any final determination or order of the commissioner made pursuant to this title shall be liable in the case of a first violation for a civil penalty not to exceed twenty-five hundred dollars and an additional penalty of not more than one thousand dollars for each day during which such violation continues, to be assessed by the commissioner after an opportunity to be heard pursuant to the provisions of this chapter or by the court in any action or proceeding pursuant to this chapter, and, in addition thereto, such person may by similar process be enjoined from continuing such violation and any permit or certificate issued to such person may be revoked or suspended or a pending renewal application denied. In the case of a second and any further violation, the liability shall be for a civil penalty not to exceed five thousand dollars for each such

violation and an additional penalty not to exceed twenty-five hundred dollars for each day during which such violation continues.

2. No penalty assessed or imposed pursuant to the provisions of this title shall be paid from medicaid or medicare funds.

ARTICLE 13-A

STATE CAMP SAFETY ADVISORY COUNCIL

Section 1390. Establishment of state camp safety advisory council.

§ 1390. Establishment of state camp safety advisory council. The commissioner of health shall establish within the state department of health a state camp safety advisory council to advise and consult on policy matters relating to youth camp safety. The council shall consist of nine members to be appointed by the governor with the advice and consent of the senate. Three members of the council shall be representatives of youth camps operated in New York for profit, three members of the council shall be representatives of youth camps operated in New York under philanthropic non-profit or charitable auspices, one member of the council shall be a representative of youth camp consumer interests, one shall be a representative of children's interests who does not operate a children's camp and one shall be a representative of summer day camps and traveling summer day camps operated by municipal corporations and other entities subject to article thirteen-D of this chapter. The council shall elect from among its members a chairman. On or before January first, nineteen hundred seventy-four, the governor shall appoint two youth camp representative members for a term of two years, two youth camp representative members for a term of four years and two youth camp representative members for a term of six years. Biennially thereafter the youth camp representative members shall be appointed to said council in like manner to succeed those whose terms expire, to serve for terms of six years each and until their successors are appointed. The member representative of youth camp consumer interests shall also serve for a term of six years and until a successor is appointed. On or before January first, nineteen hundred eighty-one,

the governor shall appoint the representative of children's interests for a term of four years and the representative of summer day camps and traveling summer day camps operated by municipal corporations and other entities subject to article thirteen-D of this chapter for a term of two years. Thereafter, each succeeding representative of children's interests and each succeeding representative of said summer day camps and traveling summer day camps shall serve terms of six years each and until their successors are appointed. Vacancies shall be filled by the governor for the unexpired portion of the term. Said council shall meet at least twice a year, and more often if necessary, on the call of the chairman or on the call of the commissioner of health. The members of the council shall receive no compensation but shall be reimbursed for their reasonable traveling and other expenses incurred in the performance of their official duties. A majority of the appointed voting membership of the council shall constitute a quorum.

ARTICLE 13-B

REGULATION OF OVERNIGHT, SUMMER DAY, AND TRAVELING SUMMER DAY CAMPS FOR CHILDREN

- Section 1391. Declaration of public policy.
1392. Definitions.
- 1392-a. Requirement to check sex offender registry.
1393. Permit requirements.
1394. Children's camps; standards and regulations.
- 1394-a. Requirement to check sex offender registry.
- 1394-b. Requirement to check sex offender registry.
- 1394-c. Camps for children with developmental disabilities.
- 1394-d. Requirement to check sex offender registry.
1395. Violations; temporary restraining order.
1396. Pesticide applications.
1397. Separability.

§ 1391. Declaration of public policy. It is the declared policy of the state of New York to protect the health, safety and welfare of children attending what are commonly called children's overnight, summer day, and

traveling summer day camps.

§ 1392. Definitions. As used in this article:

1. "Children's overnight camp" shall mean a property consisting of a tract of land and any tents, vehicles, buildings or other structures that may be pertinent to its use, any part of which may be occupied by persons under eighteen years of age under general supervision for the purpose of outdoor or indoor organized activities and on which provisions are made for overnight occupancy of children. The commissioner shall have the power to except by rule from this article and the sanitary code a place or facility that is not within the intent of this definition.

2. "Summer day camp" shall mean a property consisting of a tract of land and any tents, vehicles, buildings or other structures that may be pertinent to its use, any part of which may be occupied on a scheduled basis at any time between June first and September fifteenth in any year by children under sixteen years of age under general supervision, for the purpose of indoor or outdoor organized group activities, involving nonpassive recreational activities with significant risk of injury, as such activities are defined by the department in rules and regulations, for a period of less than twenty-four hours on any day the property is so occupied, and on which no provisions are made for overnight occupancy by such children. The commissioner shall have the power to except by rule from this article and the sanitary code a place, facility or activity that is not within the intent of this definition.

3. "Traveling summer day camp" shall mean a summer day camp which regularly operates in the period between May fifteenth and September fifteenth and which regularly transports children under the age of sixteen on a regular schedule to a facility, site, or property, including any tract of land, beach, park, stadium, building, tents or other structures pertinent to its use and primarily for the purposes of organized group activity. The commissioner shall have the power to except by rule from this article and the sanitary code a place, facility

or activity that is not within the intent of this definition.

4. "Officer" shall mean the commissioner, the health commissioner of a city with a population of over fifty thousand, the health commissioner of a county or part-county health district, the state district health officer, in whose jurisdiction a children's overnight camp, summer day camp, or the primary inclement weather facility of the children's traveling summer day camp is located, or if there be no such facility then the state district health officer in whose jurisdiction the central office is located, any county health director having all the powers and duties prescribed in section three hundred fifty-two of this chapter, the state district sanitary engineer or a grade one public health administrator qualified and appointed pursuant to part eleven of the sanitary code and serving as primary administrator of all health programs in a county or part-county health district.

§ 1392-a. Requirement to check sex offender registry. Every person, firm, limited liability company, association and corporation which operates a children's overnight camp shall be required, to ascertain whether an employee or volunteer is listed on the state sex offender registry pursuant to article six-C of the correction law and the national sex offender registry using the United States department of justice national sex offender public website prior to the day such employee or volunteer commences work at said camp and annually thereafter prior to their arrival at said camp.

§ 1393. Permit requirements. 1. No person, firm, corporation, or association shall operate a children's overnight, summer day, or traveling summer day camp without first obtaining a permit from an officer.

2. An officer shall issue a permit if, after inspection, the children's overnight, summer day, or traveling summer day camp is in compliance with this chapter and the sanitary code. All permits shall expire one year from the date of issuance of such permit or upon such

earlier date as specified by such officer which date shall in no event be earlier than the latest date that such camps may remain open pursuant to regulations prescribed by the commissioner. Nothing in this section shall be construed to limit the responsibilities and duties of compliance arising out of any other provision of law.

3. Notwithstanding any other provision of law, an officer in issuing a permit may waive any requirement of the sanitary code setting a minimum standard of floor space per camper in a camp's sleeping quarters. Such a waiver may be granted upon written application therefor, and shall be accompanied by a statement by the officer of the specific terms and conditions under which the waiver shall have been granted. Such waivers may be granted only to camps constructed prior to January first, nineteen hundred seventy-five. An officer shall grant such waiver where the application therefor is accompanied by a written certification by the local health officer of its need or desirability to avoid an immediate undue hardship upon the operator which may result in the closing of the children's overnight camp to prospective campers, and a statement by the local health officer that the granting of a waiver shall not present a hazard to public health and safety. All such waivers shall expire on December thirty-first of the year in which they are granted, but may be renewed for good and sufficient reason.

4. The fee for a permit shall be two hundred dollars, except that no fee shall be charged in the case of a children's overnight, summer day or traveling summer day camp operated by a person, firm, corporation or association for charitable, philanthropic or religious purposes.

5. Any enrollment application forms and/or enrollment contract forms mailed or delivered to a person for purposes of enrollment of a child for any children's overnight, summer day, or traveling summer day camp shall contain or be accompanied by a written statement which declares:

(a) that such camp is required to be licensed by the New York state department of health;

(b) that such camp is required to be inspected twice yearly; and

(c) the address where inspection reports concerning such camp are filed.

§ 1394. Children's camps; standards and regulations. 1. The public health and health planning council shall prescribe standards and establish regulations for children's overnight, summer day and traveling summer day camps, as defined in this article, concerning such matters as may be appropriate for the protection and security of the life, health and safety of the occupants of such camps.

2. All buses or other motor vehicles which are owned by a traveling summer day camp or which are operated or leased by such camp for the purpose of transporting children attending such camp shall meet the requirements for safe operation of such vehicles as provided for in section one hundred forty of the transportation law.

3. Notwithstanding the provisions of Title VIII of the education law, any person, firm, corporation, or association that operates a children's overnight, summer day, or traveling summer day camp, and has obtained a permit pursuant to section thirteen hundred ninety-three of this article, shall be authorized to employ or contract with a physician, nurse practitioner, physician assistant, registered nurse, or licensed practical nurse or emergency medical technician to act as a designated camp health director or to provide health services in assistance to the camp health director for the sole purpose of providing health services that benefit campers and staff at the camp while the camp is in operation. In cases where the camp health director's lawful scope of practice is more limited than that of the licensed professional providing services, the camp health director shall not supervise the provision of such treatment, but shall be informed of such treatment as medically necessary to ensure the well-being of the camper and staff. In cases where an emergency medical technician is the camp health director, the emergency medical technician shall not supervise the provision of treatment by the licensed professional providing services, but shall be informed of such treatment as medically necessary to ensure the well-being of the camper and staff.

4. Each children's overnight camp, summer day camp and travelling

summer day camp shall allow children attending such camp to carry and use topical sunscreen products approved by the federal Food and Drug Administration for over-the-counter use for the purpose of avoiding overexposure to the sun and not for medical treatment of an injury or illness, with the written permission of the parent or guardian of the child. A record of such permission shall be maintained by the camp. A child who is unable to physically apply sunscreen may be assisted by unlicensed personnel when directed to do so by the child, if permitted by a parent or guardian and authorized by the camp.

5. Each children's overnight camp, summer day camp and traveling summer day camp shall allow children attending such camp to carry and use insect repellent with the written permission of a parent or guardian of any child. A record of such permission shall be maintained by the camp. A child who is unable to physically apply insect repellent may be assisted by unlicensed personnel when directed to do so by the child, if permitted by a parent or guardian and authorized by the camp.

6. Notwithstanding the provisions of Title VIII of the education law, any person, firm, corporation, or association that operates a children's overnight, summer day, or traveling summer day camp, and has obtained a permit pursuant to section thirteen hundred ninety-three of this article, shall be authorized to employ or contract with individuals licensed under articles one hundred fifty-three, one hundred fifty-four, one hundred sixty-three and one hundred sixty-seven of the education law to provide mental health services for any period during which the camp has a valid permit to operate and for the sole purpose of providing health services that benefit campers and staff at the camp while the camp is in operation. Individuals hired under this section shall communicate with the camp health director when medically necessary.

7. All decisions, identification or coordination of professional services, or other professional interactions with campers and staff, must be made based on the professional judgment of such licensees to provide professional services within his or her lawful scope of practice for the purpose of treating campers and staff during their attendance or employment at such camp, pursuant to applicable regulations promulgated

by the commissioner in consultation with the commissioner of education.

8. Nothing in this section shall be construed to limit the authority of another state agency if such state agency is otherwise authorized under another provision of law to certify, license, contract or authorize such camp, nor shall the authority to hire individuals licensed pursuant to this section be construed to provide an exemption of such camp from any certification, licensure, or any other such requirement established by such state agency or under any other provision of law.

9. A camp that employs or contracts with an individual licensed under articles one hundred fifty-three, one hundred fifty-four, one hundred sixty-three and one hundred sixty-seven of the education law under this section shall list such individuals in their general consent form.

§ 1394-a. Requirement to check sex offender registry. Every person, firm, limited liability company, association and corporation which operates a summer day camp shall be required, to ascertain whether an employee or volunteer is listed on the state sex offender registry pursuant to article six-C of the correction law and the national sex offender registry using the United States department of justice national sex offender public website prior to the day such employee or volunteer commences work at said camp and annually thereafter prior to their arrival at said camp.

§ 1394-b. Requirement to check sex offender registry. Every person, firm, limited liability company, association and corporation which operates a traveling summer day camp shall be required, to ascertain whether an employee or volunteer is listed on the state sex offender registry pursuant to article six-C of the correction law and the national sex offender registry using the United States department of justice national sex offender public website prior to the day such employee or volunteer commences work at said camp and annually thereafter prior to their arrival at said camp.

§ 1394-c. Camps for children with developmental disabilities. 1. Camps for children with developmental disabilities, as defined in regulations, and in compliance with the justice center for the protection of people with special needs, shall be authorized to employ or contract with any of the individuals licensed under articles one hundred thirty-two, one hundred thirty-six, one hundred fifty-six, one hundred fifty-nine, one hundred sixty-two and one hundred sixty-seven of the education law, to provide professional services for any period during which the camp has a valid permit to operate. Individuals hired under this section shall communicate with the camp health director when medically necessary for the sole purpose of providing health services that benefit campers and staff at the camp while the camp is in operation. In cases where the camp health director's lawful scope of practice is more limited than that of the licensed professional providing services, the camp health director shall not supervise the provision of such treatment, but shall be informed of such treatment as medically necessary to ensure the well-being of the camper and staff.

2. All decisions, identification or coordination of professional services, or other professional interactions with campers and staff, must be made based on the professional judgment of such licensees to provide professional services within his or her lawful scope of practice for the purpose of treating campers and staff during their attendance or employment at such camp, pursuant to applicable regulations promulgated by the commissioner in consultation with the commissioner of education.

3. Nothing in this section shall be construed to limit the authority of another state agency if such state agency is otherwise authorized under another provision of law to certify, license, contract or authorize such camp, nor shall the authority to hire licensed professionals pursuant to this section be construed to provide an exemption of such camp from any certification, licensure, or any other such requirement established by such state agency or under any other provision of law.

§ 1394-d. Requirement to check sex offender registry. Every person, firm, limited liability company, association and corporation which operates a children's non-regulated camp as defined in section three hundred ninety-eight-f of the general business law shall be required to ascertain whether an employee or volunteer is listed on the state sex offender registry pursuant to article six-C of the correction law and the national sex offender registry using the United States department of justice national sex offender public website prior to the day such employee or volunteer commences work at such camp and annually thereafter prior to their arrival at such camp.

§ 1395. Violations; temporary restraining order. 1. A violation of this chapter or of the sanitary code in the operation of a children's overnight, summer day, or traveling summer day camp shall constitute a public nuisance which may be enjoined or restrained.

2. When an officer has cause to believe that there has been a violation of this chapter or the sanitary code in the operation of a children's overnight, summer day, or traveling summer day camp which does not constitute a public health hazard as defined by the sanitary code, and that such violation has continued for more than three days after notice of the violation and demand for discontinuance and abatement thereof has been served in writing on the children's overnight, summer day, or traveling summer day camp operator in the manner prescribed for the service of summons set forth in the civil practice law and rules, an officer may:

(a) Conduct a hearing upon at least three days notice served on the camp operator in the manner prescribed for the service of summons as set forth in the civil practice law and rules, and

(b) Make a determination after such hearing with respect to the alleged violation or violations and have the power to assess a fine on the children's overnight, summer day, or traveling summer day camp operator not to exceed two hundred fifty dollars for each violation for each day succeeding the third day after the notice of violation and demand for discontinuance and abatement thereof has been given, and

(c) With respect to the hearing set forth herein the officer in accordance with the civil practice law and rules may: issue subpoena, compel the attendance of witnesses, and administer oaths to witnesses, and

(d) Make an ex parte application to the supreme court of the state of New York for a temporary restraining order which the court may grant when it determines that there is a violation which requires immediate relief.

3. When an officer has cause to believe that there has been a violation of this chapter or the sanitary code in the operation of children's overnight, summer day, or traveling summer day camp which constitutes a public health hazard as defined by the sanitary code, and after notice of the violation has been served in writing on the children's overnight, summer day, or traveling summer day camp operator in the manner prescribed for the service of summons set forth in the civil practice law and rules, an officer may:

(a) Conduct a hearing upon at least fifteen days notice in accordance with the provisions of section twelve-a of this chapter served on the camp operator in the manner prescribed for the service of summons as set forth in the civil practice law and rules, and

(b) Make a determination after such hearing with respect to the alleged violation or violations and have the power to assess a fine on the children's overnight, summer day, or traveling summer day camp operator in accordance with the provisions of section twelve of this chapter for each violation, and

(c) With respect to the hearing set forth herein the officer in accordance with the civil practice law and rules may: issue subpoena, compel the attendance of witnesses, and administer oaths to witnesses, and

(d) Make an ex parte application to the supreme court of the state of New York for a temporary restraining order which the court may grant when it determines that there is a violation which requires immediate relief.

4. The officer may appoint one or more hearing officers as shall be necessary to do or perform in his place or stead the acts authorized by

paragraphs (a) and (c) of subdivision two of this section. The hearing officer shall make findings of fact and submit recommendations to the officer.

5. An officer may institute proceedings to enjoin the continuance of such violation or the continued operation of such camp. No bond or undertaking shall be required of such officer in such proceedings and no application to vacate or modify any judgment obtained shall be entertained by any court without proof to such court that ten days notice of such application, and copies of the papers upon which the application is to be made, have been served upon such officer.

6. Nothing contained in this section shall be construed to limit the duty or power of an officer to act with regard to an immediate threat to the health of the occupants of a children's overnight, summer day, or traveling summer day camp or the community in which it is located, or to alter or abridge any of the duties and powers now or hereafter existing in the commissioner, state district health officers, county boards of health, county commissioners of health or local boards of health.

7. Nothing contained in this section shall be construed to limit or preclude the officer from enforcing or pursuing any remedies or penalties available under this chapter or sanitary code with respect to violations which constitute a public health hazard as defined by the sanitary code, in the operation of the children's overnight, summer day, or traveling summer day camp, including, but not limited to, those remedies or penalties available under sections twelve, sixteen, two hundred six, two hundred twenty-nine, three hundred nine, and three hundred forty-eight of this chapter.

§ 1396. Pesticide applications. 1. For purposes of this section "pesticide" shall have the same meaning as set forth in subdivision thirty-five of section 33-0101 of the environmental conservation law, provided however that the following pesticide application shall be exempt:

(a) the application of anti-microbial pesticides as defined by FIFRA

in 7 U.S.C. Section 136 (mm) and 136 q (h) (2);

(b) the use of an aerosol product with a directed spray, in containers of eighteen fluid ounces or less, when used to protect individuals from an imminent threat from stinging and biting insects, including venomous spiders, bees, wasps and hornets;

(c) the use of non-volatile insect or rodent bait in a tamper resistant container;

(d) the application of a pesticide classified by the United States Environmental Protection Agency as an exempt material under 40 CFR Part 152.25;

(e) the use of boric acid and disodium octaborate tetrahydrate; or

(f) the use of horticultural soap and oils that do not contain synthetic pesticides or synergists.

2. No person shall apply pesticide to any playground, turf or athletic or playing field at any camp as defined pursuant to subdivisions one and two of section thirteen hundred ninety-two of this article, or children's non-regulated camp as defined pursuant to section three hundred ninety-eight-f of the general business law, other than those on publicly-owned or publicly-leased property in a city of more than one million, except that: (a) an emergency application of a pesticide may be made by a camp defined in subdivisions one and two of section thirteen hundred ninety-two of this article as determined by the county health department or for a county served by a district office of the department of health, such authority as the county legislature shall designate, the commissioner or his or her designee; and (b) an emergency application of a pesticide may be made by a children's non-regulated camp defined in section three hundred ninety-eight-f of the general business law as determined by the commissioner or his or her designee.

§ 1397. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment

shall have been rendered.

ARTICLE 13-D

REGULATION OF HOUSING; USED AS ACCOMMODATIONS BY EMPLOYEES OF CERTAIN MOTELS AND HOTELS

Section 1399-j. Definitions.

1399-k. Violations notice; administrative procedure; temporary
restraining order.

1399-l. Application.

1399-m. Separability.

§ 1399-j. Definitions. As used in this article:

1. "Motel or hotel" shall mean establishments distinguished as hotels, motels, bungalow colonies, or any other establishment comparable or equivalent to any of those previously mentioned. The term shall not include those places or facilities not having the general characteristics of a motel or hotel as that term is generally understood and the State Commissioner of Health shall have the power to except from this article and the Sanitary Code a place or facility that is not within the intent of this definition of a motel or hotel.

2. "Officer" shall mean the health commissioner of a city of fifty thousand population and over or of a county or part-county health district, or the state district health officer, in whose jurisdiction a hotel or motel is located or any county health director having all the powers and duties prescribed in section three hundred fifty-two of this chapter.

§ 1399-k. Violations notice; administrative procedure; temporary restraining order. 1. A violation of the public health law or of the sanitary code relating to the housing of motel and hotel employees shall constitute a public nuisance which may be enjoined or restrained.

2. When an officer has cause to believe that there has been a violation of the public health law or of the sanitary code or any other rules or regulations promulgated pursuant to article nineteen of the labor law in the housing of motel and hotel employees and that such violation has continued for more than three days after notice of the violation and demand for discontinuance and abatement thereof has been served in writing on the owner or his agent authorized to receive legal notice in the manner prescribed for the service of summons set forth in the civil practice law and rules, an officer may:

(a) Conduct a hearing upon at least three days notice served on the owner or his aforementioned agent in the manner prescribed for the service of summons as set forth in the civil practice law and rules, and

(b) Make a determination after such hearing with respect to the alleged violation or violations and have the power to assess a fine on the owner of such motel or hotel not to exceed two hundred fifty dollars for each violation for each day succeeding the third day after the notice of violation and demand for discontinuance and abatement thereof has been given, and

(c) With respect to the hearing set forth herein the officer in accordance with the civil practice law and rules may: issue subpoena, compel the attendance of witnesses, and administer oaths to witnesses, and

(d) Make an ex parte application to the supreme court of the state of New York for a temporary restraining order which the court may grant when it determines that there is a violation which requires immediate relief.

3. The officer may appoint one or more hearing officers as shall be necessary to do or perform in his place or stead the acts authorized by paragraphs (a) and (c) of this section. The hearing officer shall make findings of fact and submit recommendations to the officer.

4. An officer may institute proceedings to enjoin the continuance of such violation or the continued operation of such motel or hotel. No bond or undertaking shall be required of such officer in such proceedings and no application to vacate or modify any judgment obtained shall be entertained by any court without proof to such court that ten

days notice of such application, and copies of the papers upon which the application is to be made, have been served upon such officer.

5. Nothing contained in this section shall be construed to limit the duty or power of an officer to act with regard to an immediate threat to the health of the occupants of a motel or hotel or the community in which it is located, or to alter or abridge any of the duties and powers now or hereafter existing in the commissioner, state district health officers, county boards of health, county commissioners of health or local boards of health.

§ 1399-l. Application. The provisions of this article shall not apply to cities having a population of one hundred twenty-five thousand or more.

§ 1399-m. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

ARTICLE 13-E

REGULATION OF SMOKING AND VAPING IN CERTAIN PUBLIC AREAS

Section 1399-n. Definitions.

1399-o. Smoking and vaping restrictions.

1399-o-1. Smoking and vaping restrictions; certain outdoor areas.

1399-o-2. Smoking restrictions; certain outdoor areas.

1399-p. Posting of signs.

1399-q. Smoking and vaping restrictions inapplicable.

1399-r. General provisions.

1399-s. Violations.

- 1399-t. Enforcement.
- 1399-u. Waiver.
- 1399-v. Penalties.
- 1399-w. Limitation of causes of action.
- 1399-x. Rules and regulations.

§ 1399-n. Definitions. For purposes of this article:

1. "Bar" means any area, including outdoor seating areas, devoted to the sale and service of alcoholic beverages for on-premises consumption and where the service of food is only incidental to the consumption of such beverages.

2. "Employer" means any person, partnership, association, limited liability company, corporation or nonprofit entity which employs one or more persons, including the legislative, executive and judicial branches of state government and any political subdivision of the state.

3. "Food service establishment" means any area, including outdoor seating areas, or portion thereof in which the business is the sale of food for on-premises consumption.

4. "Membership association" means a not-for-profit entity which has been created or organized for a charitable, philanthropic, educational, political, social or other similar purpose.

5. "Place of employment" means any indoor area or portion thereof under the control of an employer in which employees of the employer perform services, and shall include, but not be limited to, offices, school grounds, retail stores, banquet facilities, theaters, food stores, banks, financial institutions, factories, warehouses, employee cafeterias, lounges, auditoriums, gymnasiums, restrooms, elevators, hallways, museums, libraries, bowling establishments, employee medical facilities, rooms or areas containing photocopying equipment or other office equipment used in common, and company vehicles.

6. "School grounds" means any building, structure, and surrounding outdoor grounds contained within a public or private pre-school, nursery school, elementary or secondary school's legally defined property boundaries as registered in a county clerk's office, and any vehicles used to transport children or school personnel.

7. "Retail tobacco business" means a sole proprietorship, limited liability company, corporation, partnership or other enterprise in which the primary activity is the retail sale of tobacco products and accessories, and in which the sale of other products is merely incidental.

8. "Smoking" means the burning of a lighted cigar, cigarette, pipe or any other matter or substance which contains tobacco or cannabis as defined in section 222.00 of the penal law, or cannabinoid hemp as defined in section three of the cannabis law.

9. "Vaping" means the use of an electronic cigarette.

10. "Electronic cigarette" shall have the same meaning as in subdivision thirteen of section thirteen hundred ninety-nine-aa of this chapter.

11. "Retail electronic cigarette store" means a retail store devoted primarily to the sale of electronic cigarettes, and in which the sale of other products is merely incidental. The sale of such other products shall be considered incidental if such sales generate less than twenty-five percent of the total annual gross sales.

§ 1399-o. Smoking and vaping restrictions. 1. Smoking and vaping shall not be permitted and no person shall smoke or vape in the following indoor areas:

- a. places of employment;
- b. bars;

c. food service establishments, except as provided in subdivision six of section thirteen hundred ninety-nine-q of this article;

d. enclosed indoor areas open to the public containing a swimming pool;

e. public means of mass transportation, including subways, underground subway stations, and when occupied by passengers, buses, vans, taxicabs and limousines;

f. ticketing, boarding and waiting areas in public transportation terminals;

g. youth centers and facilities for detention as defined in sections five hundred twenty-seven-a and five hundred three of the executive law;

h. any facility that provides child care services as defined in section four hundred ten-p of the social services law, provided, however, that rooms in such a facility that is a private home shall be regulated by this paragraph as follows:

(i) when such private home is not required to be licensed or registered for such services by the office of children and family services, rooms in such home are excluded from the prohibition of this paragraph during periods when children receiving such services are not present; and

(ii) when such private home is required to be licensed or registered for such services by the office of children and family services, rooms in such home are included within the prohibition of this paragraph, regardless of whether or not children receiving such services are present.

i. child day care centers as defined in section three hundred ninety of the social services law and child day care centers licensed by the city of New York;

j. group homes for children as defined in section three hundred

seventy-one of the social services law;

k. public institutions for children as defined in section three hundred seventy-one of the social services law;

l. residential treatment facilities for children and youth as defined in section 1.03 of the mental hygiene law;

m. all public and private colleges, universities and other educational and vocational institutions, including dormitories, residence halls, and other group residential facilities that are owned or operated by such colleges, universities and other educational and vocational institutions, except that these restrictions shall not apply in any off-campus residential unit occupied by a person who is not enrolled as an undergraduate student in such college, university or other educational or vocational institution;

n. general hospitals and residential health care facilities as defined in article twenty-eight of this chapter, and other health care facilities licensed by the state in which persons reside; provided, however, that the provisions of this subdivision shall not prohibit smoking and vaping by patients in separate enclosed rooms of residential health care facilities, adult care facilities established or certified under title two of article seven of the social services law, community mental health residences established under section 41.44 of the mental hygiene law, or facilities where day treatment programs are provided, which are designated as smoking and vaping rooms for patients of such facilities or programs;

o. commercial establishments used for the purpose of carrying on or exercising any trade, profession, vocation or charitable activity;

p. indoor arenas;

q. zoos; and

r. bingo facilities.

2. Smoking and vaping shall not be permitted and no person shall smoke or vape in the following outdoor areas:

a. ticketing, boarding or platform areas of railroad stations operated by the metropolitan transportation authority or its subsidiaries.

b. on the grounds of general hospitals and residential health care facilities as defined in article twenty-eight of this chapter, within fifteen feet of a building entrance or exit or within fifteen feet of the entrance to or exit from the grounds of any such general hospital or residential health care facility. This subdivision shall not prohibit smoking and vaping by a patient or a visitor or guest of a patient of a residential health care facility in a separate area on the grounds designated as a smoking and vaping area by the residential health care facility, provided such designated smoking and vaping area is not within thirty feet of any building structure (other than a non-residential structure wholly contained within the designated smoking and vaping area), including any overhang, canopy, awning, entrance, exit, window, intake or exhaust.

3. Smoking and vaping shall not be permitted and no person shall smoke or vape within one hundred feet of the entrances, exits or outdoor areas of any public or private elementary or secondary schools; provided, however, that the provisions of this subdivision shall not apply to smoking or vaping in a residence, or within the real property boundary lines of such residential real property. The provisions of section thirteen hundred ninety-nine-p of this article shall not apply to this subdivision.

4. Smoking and vaping shall not be permitted and no person shall smoke or vape within one hundred feet of the entrances, exits or outdoor areas of any after-school program licensed or registered pursuant to section three hundred ninety of the social services law; provided, however, that the provisions of this subdivision shall only apply on those days and during those hours in which such after-school programs are operational; and provided, further, that the provisions of this subdivision shall not

apply to smoking or vaping in a residence, or within the real property boundary lines of such residential real property.

5. a. Use of an electronic cigarette or e-cigarette shall not be permitted on school grounds, as defined in subdivision six of section thirteen hundred ninety-nine-n of this article.

b. "Electronic cigarette" or "e-cigarette" shall have the same meaning as in subdivision thirteen of section thirteen hundred ninety-nine-aa of this chapter.

6. Smoking shall not be permitted and no person shall smoke within one hundred feet of the entrances, exits or outdoor areas of any public or association library as defined in subdivision two of section two hundred fifty-three of the education law; provided, however, that the provisions of this subdivision shall not apply to smoking in a residence, or within the real property boundary lines of such residential real property.

§ 1399-o-1. Smoking and vaping restrictions; certain outdoor areas. 1. Smoking and vaping shall not be permitted and no person shall smoke or vape during the hours between sunrise and sunset, when one or more persons under the age of twelve are present at any playground. For the purposes of this section, the term "playground" means an improved area designed, equipped, and set aside for play of six or more children which is not intended for use as an athletic playing field or athletic court, and shall include any play equipment, surfacing, fencing, signs, internal pathways, internal land forms, vegetation, and related structures. Playgrounds or playground equipment constructed upon one, two and three-family residential real property are exempt from the requirements of this section. This section shall not apply to any playground located within the city of New York.

2. No police officer, peace officer, regulatory officer or law enforcement official may arrest, ticket, stop or question any person based solely or in part on an alleged violation of subdivision one of this section, nor may an alleged violation of subdivision one of this

section support probable cause to conduct any search or limited search of any person or his or her immediate surroundings.

§ 1399-o-2. Smoking restrictions; certain outdoor areas. 1. Smoking shall not be permitted and no person shall smoke in any public park.

2. For the purposes of this section "park" shall mean:

(a) public parks, beaches, pools, boardwalks, marinas, playgrounds, recreation centers, and group camps; and

(b) equipment, buildings and facilities now or hereafter under the jurisdiction, charge or control of any state or local government agency or department that are located at or on any property described in paragraph (a) of this subdivision; provided, however, that for the purposes of this section the term public park shall not include the Adirondack park or the Catskill park as those terms are defined in section 9-0101 of the environmental conservation law.

3. The provisions of this section shall not apply to: (a) the sidewalks immediately adjoining parks, squares and public places; (b) any pedestrian route through any park strip, median or mall that is adjacent to vehicular traffic; (c) parking lots or roadways; (d) theatrical productions; and (e) any portion of a park that is not used for park purposes, except when smoking has been specifically prohibited in a state park or portion thereof by the office of parks, recreation and historic preservation. This subdivision shall not limit the applicability of any other laws to such places.

§ 1399-p. Posting of signs. 1. "Smoking" or "No Smoking" signs, or "Vaping" or "No Vaping" signs, or the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a circle with a bar across it, shall be prominently posted and properly maintained where smoking and vaping are regulated by this article, by the owner, operator, manager or other person having control of such area.

2. The owner, operator or manager of a hotel or motel that chooses to develop and implement a smoking and vaping policy for rooms rented to guests shall post a notice at the reception area of the establishment as to the availability, upon request, of rooms in which no smoking and vaping are allowed.

3. The provisions of this section shall apply to after-school programs that are subject to the provisions of subdivision four of section thirteen hundred ninety-nine-o of this article, provided that signs posted pursuant to this subdivision shall specify the specific time period during which smoking and vaping shall be prohibited.

§ 1399-q. Smoking and vaping restrictions inapplicable. 1. This article shall not apply to:

- (a) Private homes and private residences;
- (b) Private automobiles;
- (c) A hotel or motel room rented to one or more guests;
- (d) Retail tobacco businesses;

(e) Membership associations; provided, however, that smoking and vaping shall only be allowed in membership associations in which all of the duties with respect to the operation of such association, including, but not limited to, the preparation of food and beverages, the service of food and beverages, reception and secretarial work, and the security services of the membership association are performed by members of such membership association who do not receive compensation of any kind from the membership association or any other entity for the performance of such duties;

(f) Cigar bars that, in the calendar year ending December thirty-first, two thousand two, generated ten percent or more of its total annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, not including any sales from vending machines, and is registered with the appropriate enforcement officer, as defined in subdivision one of section thirteen hundred ninety-nine-t of this article. Such registration shall remain in effect for one year and shall be renewable only if: (a) in the preceding calendar year, the cigar bar generated ten percent or more of its total annual gross income

from the on-site sale of tobacco products and the rental of on-site humidors, and (b) the cigar bar has not expanded its size or changed its location from its size or location since December thirty-first, two thousand two;

(g) Outdoor dining areas of food service establishments with no roof or other ceiling enclosure; provided, however, that smoking and vaping may be permitted in a contiguous area designated for smoking and vaping so long as such area: (a) constitutes no more than twenty-five percent of the outdoor seating capacity of such food service establishment, (b) is at least three feet away from the outdoor area of such food service establishment not designated for smoking and vaping, and (c) is clearly designated with written signage as a smoking and vaping area;

(h) Enclosed rooms in food service establishments, bars, catering halls, convention halls, hotel and motel conference rooms, and other such similar facilities during the time such enclosed areas or rooms are being used exclusively for functions where the public is invited for the primary purpose of promoting and sampling tobacco products or electronic cigarettes, and the service of food and drink is incidental to such purpose, provided that the sponsor or organizer gives notice in any promotional material or advertisements that smoking and vaping will not be restricted, and prominently posts notice at the entrance of the facility and has provided notice of such function to the appropriate enforcement officer, as defined in subdivision one of section thirteen hundred ninety-nine-t of this article, at least two weeks prior to such function. The enforcement officer shall keep a record of all tobacco sampling events, and such record shall be made available for public inspection. No such facility shall permit smoking and vaping under this subdivision for more than two days in any calendar year;

(i) Retail electronic cigarette stores, provided however, that such stores may only permit the use of electronic cigarettes; and

(j) Adult-use on-site consumption premises authorized pursuant to article four of the cannabis law, provided however, that such locations may only permit the smoking or vaping of cannabis.

2. The restrictions of this article on the smoking or vaping of cannabis shall continue to apply to those locations identified in paragraphs (b), (d), (f), (g), (h) and (i) of subdivision one of this

section.

§ 1399-r. General provisions. 1. Nothing in this article shall be construed to deny the owner, operator or manager of a place covered by this article the right to designate the entire place, or any part thereof, as a nonsmoking and nonvaping area.

2. The provisions of this article shall apply to the legislative, executive and judicial branches of state government and any political subdivision of the state.

3. Smoking and vaping may not be permitted where prohibited by any other law, rule, or regulation of any state agency or any political subdivision of the state. Nothing herein shall be construed to restrict the power of any county, city, town, or village to adopt and enforce additional local law, ordinances, or regulations which comply with at least the minimum applicable standards set forth in this article.

§ 1399-s. Violations. 1. It shall be unlawful for any person, firm, limited liability company, corporation or other entity that owns, manages, operates or otherwise controls the use of an area in which smoking and vaping is prohibited or restricted pursuant to section thirteen hundred ninety-nine-o of this article to fail to comply with the provisions of this article. For violations of this subdivision, it shall be an affirmative defense that during the relevant time period actual control of the area was not exercised by the respondent, but rather by a lessee, the sublessee or any other person. To establish an affirmative defense, the respondent shall submit an affidavit and may submit any other relevant proof indicating that the respondent did not exercise actual control of said area during the relevant time period. Such affidavit and other proof shall be mailed by certified mail to the appropriate enforcement officer within thirty days of receipt of such notice of violation.

2. It shall be unlawful for an employer whose place of employment is

subject to subdivision one of section thirteen hundred ninety-nine-o of this article to fail to comply with the provisions of such subdivision. For violations of such subdivision, it shall be an affirmative defense that the employer has made good faith efforts to ensure that employees comply with the provisions of this article.

3. It shall be unlawful for any person to smoke or vape in any area where smoking and vaping is prohibited or restricted under section thirteen hundred ninety-nine-o of this article.

§ 1399-t. Enforcement. 1. For the purpose of this article the term "enforcement officer" shall mean the board of health of a county or part county health district established pursuant to title three of article three of this chapter, or in the absence thereof, an officer of a county designated for such purpose by resolution of the elected county legislature or board of supervisors adopted within sixty days after the effective date of this article. Any such designation shall be filed with the commissioner within thirty days after adoption. If no such designation is made, the county will be deemed to have designated the department as its enforcement officer. Any county that does not designate an enforcement officer during the time period specified above may do so at any time, thereafter, such designation will be effective thirty days after it is filed with the commissioner. The enforcement officer shall have sole jurisdiction to enforce the provisions of this article on a county-wide basis pursuant to rules and regulations promulgated by the commissioner. In a city with a population of more than one million the enforcement officer shall be the department of health and mental hygiene of such city which shall have sole jurisdiction to enforce the provisions of this article in such city.

2. If the enforcement officer determines after a hearing that a violation of this article has occurred, a civil penalty may be imposed by the enforcement officer pursuant to section thirteen hundred ninety-nine-v of this article. When the enforcement officer is the commissioner, the hearing shall be conducted pursuant to the provisions of section twelve-a of this chapter. When the enforcement officer is a

board of health or in a city with a population of more than one million, the department of health and mental hygiene, or an officer designated to enforce the provisions of this article, the hearing shall be conducted pursuant to procedures set forth in the county sanitary code, or health code of such city, or in the absence thereof, pursuant to procedures established by the elected county legislature or board of supervisors. No other penalty, fine or sanction may be imposed, provided that nothing herein shall be construed to prohibit an enforcement officer from commencing a proceeding for injunctive relief to compel compliance with this article.

3. Any person who desires to register a complaint under this article may do so with the appropriate enforcement officer.

4. The owner, manager, operator or other person having control of any area subject to the provisions of this article, shall inform, or shall designate an agent who shall be responsible for informing individuals smoking or vaping in an area in which smoking or vaping is not permitted that they are in violation of this article.

5. Any person aggrieved by the decision of an enforcement officer other than the commissioner may appeal to the commissioner to review such decision within thirty days of such decision. The decision of any enforcement officer shall be reviewable pursuant to article seventy-eight of the civil practice law and rules.

6. The enforcement officer, subsequent to any appeal having been finally determined, may bring an action to recover the civil penalty provided in section thirteen hundred ninety-nine-v of this article in any court of competent jurisdiction.

7. An enforcement officer who discovers a retail dealer who or which does not display a retail dealer certificate of license or registration from the department of taxation and finance issued pursuant to section four hundred eighty-a of the tax law shall notify the commissioner of taxation and finance within thirty days of the name and address of any such establishment so that the commissioner of taxation and finance can

take appropriate action.

§ 1399-u. Waiver. 1. The enforcement officer may grant a waiver from the application of a specific provision of this article, provided that prior to the granting of any such waiver the applicant for a waiver shall establish that:

(a) compliance with a specific provision of this article would cause undue financial hardship; or

(b) other factors exist which would render compliance unreasonable.

2. Every waiver granted shall be subject to such conditions or restrictions as may be necessary to minimize the adverse effects of the waiver upon persons subject to an involuntary exposure to second-hand smoke or vaping and to ensure that the waiver is consistent with the general purpose of this article.

§ 1399-v. Penalties. The commissioner may impose a civil penalty for a violation of this article in an amount not to exceed that set forth in subdivision one of section twelve of this chapter. Any other enforcement officer may impose a civil penalty for a violation of this article in an amount not to exceed that set forth in paragraph (f) of subdivision one of section three hundred nine of this chapter. Notwithstanding the foregoing provisions, a violation of the provisions of section thirteen hundred ninety-nine-o-two of this article shall be punishable by a civil penalty of fifty dollars for each violation.

§ 1399-w. Limitation of causes of action. An employer, administrator, manager, owner or operator of any indoor area, food service establishment, or place of employment regulated by this article who complies or fails to comply with the provisions of this article shall not be subject to any legal liability or action solely as a result of such compliance or noncompliance except as provided in section thirteen hundred ninety-nine-v of this article. Nothing in any other section of this article shall be construed to create, impair, alter, limit, modify,

enlarge, abrogate or restrict any theory of liability upon which any person may be held liable to any other person for exposure to smoke or vaping.

§ 1399-x. Rules and regulations. The commissioner shall not promulgate any rules or regulations to effectuate the provisions of section thirteen hundred ninety-nine-n, paragraph f of subdivision one of section thirteen hundred ninety-nine-o or subdivision one of section thirteen hundred ninety-nine-p of this article. The commissioner shall not promulgate any rules or regulations that create, limit or enlarge any smoking or vaping restrictions.

ARTICLE 13-F

REGULATION OF TOBACCO PRODUCTS, HERBAL CIGARETTES AND SMOKING PARAPHERNALIA; DISTRIBUTION TO MINORS

- Section 1399-aa. Definitions.
- 1399-bb. Distribution of tobacco products, vapor products, or herbal cigarettes without charge.
- 1399-bb-1. Promotions prohibited.
- 1399-cc. Sale of tobacco products, herbal cigarettes, liquid nicotine, shisha, rolling papers or smoking paraphernalia to minors prohibited.
- 1399-dd. Sale of tobacco products, herbal cigarettes or electronic cigarettes in vending machines.
- 1399-dd-1. Public display of tobacco product and electronic cigarette advertisements and smoking paraphernalia prohibited.
- 1399-ee. Hearings; penalties.
- 1399-ff. Enforcement.
- 1399-gg. Out-of-package sales and minimum package sizes.
- 1399-hh. Tobacco and vapor product enforcement.
- 1399-ii. Tobacco and vapor product use prevention and control program.
- 1399-ii-1. Electronic cigarette and vaping prevention, awareness and control program.

- 1399-jj. Evaluation requirements.
- 1399-kk. Annual tobacco and vapor product enforcement reporting.
- 1399-ll. Unlawful shipment or transport of cigarettes and vapor products.
- 1399-ll*2. Sale of bidis prohibited.
- 1399-mm. Sale of gutka prohibited.
- 1399-mm-1. Sale of flavored products prohibited.
- 1399-mm-2. Sale in pharmacies.
- 1399-mm-3. Carrier oils.
- 1399-mmm. Sale of kratom prohibited.

§ 1399-aa. Definitions. As used in this article:

1. "Enforcement officer" means the enforcement officer designated pursuant to article thirteen-E of this chapter to enforce such article and hold hearings pursuant thereto; provided that in a city with a population of more than one million it shall also mean an officer or employee or any agency of such city that is authorized to enforce any local law of such city related to the regulation of the sale of tobacco products to minors, or for the purposes of section thirteen hundred ninety-nine-ee of this article, the office of administrative trials and hearings of such city.

2. "Food service establishment" means any area, including outdoor seating areas, in which the business is the sale of food for on-premises consumption.

3. "Person" means a person, firm, company, corporation, partnership, sole proprietor, limited partnership or association.

4. "Private club" means an organization with no more than an insignificant portion of its membership comprised of people under the age of twenty-one years that regularly receives dues and/or payments from its members for the use of space, facilities and services.

5. "Tobacco products" means one or more cigarettes or cigars, bidis, chewing tobacco, powdered tobacco, nicotine water or any other tobacco products.

6. "Herbal cigarette" means any product made primarily of an herb or combination of herbs, and intended to be smoked in any of the methods that tobacco is smoked, including but not limited to, as a cigarette, cigar or pipe filler.

7. "Bidis" means a product containing tobacco that is wrapped in temburni leaf (*diospyros melanoxylon*) or tendra leaf (*diospyros exculpra*), or any other product offered to consumers as "beedies" or "bidis".

8. "Tobacco business" means a sole proprietorship, corporation, limited liability company, partnership or other enterprise in which the primary activity is the sale, manufacture or promotion of tobacco, tobacco products and accessories, either at wholesale or retail, and in which the sale, manufacture or promotion of other products is merely incidental.

9. "Factory" means any mill or other manufacturing establishment where one or more persons are employed in manufacturing including making, altering, repairing, finishing, bottling, canning, cleaning or laundering any article or thing.

10. "Gutka" means a product containing lime paste, spices, areca and tobacco.

11. "Nicotine water" means bottled water that is laced with nicotine.

12. "Shisha" means any product made primarily of tobacco or other leaf, or any combination thereof, smoked or intended to be smoked in a hookah or water pipe.

13. "Electronic cigarette" or "e-cigarette" means an electronic device that delivers vapor which is inhaled by an individual user, and shall

include any refill, cartridge and any other component of such a device.

14. "Price reduction instrument" means any coupon, voucher, rebate, card, paper, note, form, statement, ticket, image, or other issue, whether in paper, digital, or any other form, used for commercial purposes to receive an article, product, service, or accommodation without charge or at a discounted price.

15. "Listed or non-discounted price" means the price listed for cigarettes, tobacco products, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine, on their packages or any related shelving, posting, advertising or display at the location where the cigarettes, tobacco products, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine, are sold or offered for sale, including all applicable taxes.

16. "Retail dealer" means a person licensed by the commissioner of taxation and finance to sell cigarettes, tobacco products, or vapor products in this state.

17. "Vapor products" means any noncombustible liquid or gel, regardless of the presence of nicotine therein, that is manufactured into a finished product for use in an electronic cigarette, including any device that contains such noncombustible liquid or gel. "Vapor product" shall not include any device, or any component thereof, that does not contain such noncombustible liquid or gel, or any product approved by the United States food and drug administration as a drug or medical device, or manufactured and dispensed pursuant to title five-A of article thirty-three of this chapter.

18. "Vapor products dealer" means a person licensed by the commissioner of taxation and finance to sell vapor products in this state.

§ 1399-bb. Distribution of tobacco products, vapor products, or herbal

cigarettes without charge. 1. No retail dealer, or any agent or employee of a retail dealer engaged in the business of selling or otherwise distributing tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes for commercial purposes, or any agent or employee of such retail dealer, or any agent or employee of a retail dealer, shall knowingly, in furtherance of such business:

(a) distribute without charge any tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes to any individual, provided that the distribution of a package containing tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes in violation of this subdivision shall constitute a single violation without regard to the number of items in the package; or

(b) distribute price reduction instruments which are redeemable for tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes to any individual, provided that this subdivision shall not apply to coupons contained in newspapers, magazines or other types of publications, coupons obtained through the purchase of tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes or obtained at locations which sell tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes provided that such distribution is confined to a designated area or to coupons sent through the mail.

1-a. No retail dealer engaged in the business of selling or otherwise distributing tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine for commercial purposes, or any agent or employee of such retail dealer, shall knowingly, in furtherance of such business:

(a) honor or accept a price reduction instrument in any transaction related to the sale of tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine to a consumer;

(b) sell or offer for sale any tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine to a consumer through any multi-package discount or otherwise provide to a consumer any tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine for less than the listed price or non-discounted price in exchange for the purchase of any other tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine by such consumer;

(c) sell, offer for sale, or otherwise provide any product other than a tobacco product, herbal cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine to a consumer for less than the listed price or non-discounted price in exchange for the purchase of a tobacco product, herbal cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine by such consumer; or

(d) sell, offer for sale, or otherwise provide a tobacco product, herbal cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine to a consumer for less than the listed price or non-discounted price.

2. The prohibitions contained in subdivision one of this section shall not apply to the following locations:

(a) private social functions when seating arrangements are under the control of the sponsor of the function and not the owner, operator, manager or person in charge of such indoor area;

(b) conventions and trade shows; provided that the distribution is confined to designated areas generally accessible only to persons over the age of twenty-one;

(c) events sponsored by tobacco, vapor product intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarette manufacturers provided that the distribution is confined to designated areas generally accessible only to persons over the age of twenty-one;

(d) bars as defined in subdivision one of section thirteen hundred ninety-nine-n of this chapter;

(e) tobacco businesses as defined in subdivision eight of section thirteen hundred ninety-nine-aa of this article;

(f) factories as defined in subdivision nine of section thirteen hundred ninety-nine-aa of this article and construction sites; provided that the distribution is confined to designated areas generally accessible only to persons over the age of twenty-one.

3. No retail dealer shall distribute tobacco products, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes at the locations set forth in paragraphs (b), (c) and (f) of subdivision two of this section unless such person gives five days written notice to the enforcement officer.

4. No retail dealer engaged in the business of selling or otherwise distributing electronic cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine for commercial purposes, or any agent or employee of such person, shall knowingly, in furtherance of such business, distribute without charge any electronic cigarettes to any individual under twenty-one years of age.

5. The distribution of tobacco products, electronic cigarettes, vapor products intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarettes pursuant to subdivision two of this section or the distribution without charge of electronic cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine, shall be made only to an individual who demonstrates, through (a) a driver's license or non-driver identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth, or possession, the District of Columbia, a state government within the United States, or a provincial government of the dominion of Canada, (b) a valid passport issued by the United States government or the government of any other country, or (c) an identification card issued by the armed forces of the United States, indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably

appears to be at least twenty-five years of age; provided, however, that such appearance shall not constitute a defense in any proceeding alleging the sale of a tobacco product, electronic cigarette, vapor product intended or reasonably expected to be used with or for the consumption of nicotine, or herbal cigarette or the distribution without charge of electronic cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine to an individual.

§ 1399-bb-1. Promotions prohibited. 1. No manufacturer and no distributor of electronic cigarettes shall market, license, distribute, sell, or cause to be marketed, licensed, distributed, or sold any item (other than electronic cigarettes, including parts, components or accessories of electronic cigarettes) or service, which bears the brand name (alone or in conjunction with any other word), logo, symbol, motto, selling message, recognizable color or pattern of colors, or any other indicia of product identification identical or similar to, or identifiable with, those used for any brand of electronic cigarette. This subdivision shall not apply to a retailer's point of sale promotional materials for electronic cigarettes.

2. No manufacturer, distributor, or retailer may offer or cause to be offered any gift or item to any person purchasing electronic cigarettes in consideration of the purchase thereof.

3. No manufacturer, distributor, or retailer may sponsor or cause to be sponsored any athletic, musical, artistic, or other social or cultural event, or any entry or team in any event, in the brand name (alone or in conjunction with any other word), logo, symbol, motto, selling message, recognizable color or pattern of colors, or any other indicia of product identification identical or similar to, or identifiable with, those used for any brand of electronic cigarette. Nothing in this subdivision prevents a manufacturer, distributor, or retailer from sponsoring or causing to be sponsored any athletic, musical, artistic, or other social or cultural event, or team or entry, in the name of the corporation which manufactures the electronic

cigarettes, provided that the corporate name does not include any brand name (alone or in conjunction with any other word), logo, symbol, motto, selling message, recognizable color or pattern of colors, or any other indicia of product identification identical or similar to, or identifiable with, those used for any brand of electronic cigarettes.

§ 1399-cc. Sale of tobacco products, herbal cigarettes, liquid nicotine, shisha, rolling papers or smoking paraphernalia to minors prohibited. 1. As used in this section:

(a) "A device capable of deciphering any electronically readable format" or "device" shall mean any commercial device or combination of devices used at a point of sale or entry that is capable of reading the information encoded on the bar code or magnetic strip of a driver's license or non-driver identification card issued by the state commissioner of motor vehicles;

(b) "Card holder" means any person presenting a driver's license or non-driver identification card to a licensee, or to the agent or employee of such licensee under this chapter;

(c) "Smoking paraphernalia" means any pipe, water pipe, hookah, rolling papers, vaporizer or any other device, equipment or apparatus designed for the inhalation of tobacco;

(d) "Transaction scan" means the process involving an automated bar code reader by which a licensee, or agent or employee of a licensee under this chapter reviews a driver's license or non-driver identification card presented as a precondition for the purchase of a tobacco product or herbal cigarettes pursuant to subdivision three of this section; and

(e) "Liquid nicotine", "electronic liquid" or "e-liquid" means a liquid composed of nicotine and other chemicals, and which is sold as a product that may be used in an electronic cigarette.

2. Any person operating a place of business wherein tobacco products, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes, are sold or offered for sale is prohibited from selling such products, herbal cigarettes, liquid nicotine, shisha, electronic cigarettes or smoking paraphernalia to individuals under twenty-one years of age, and

shall post in a conspicuous place a sign upon which there shall be imprinted the following statement, "SALE OF CIGARETTES, CIGARS, CHEWING TOBACCO, POWDERED TOBACCO, SHISHA OR OTHER TOBACCO PRODUCTS, HERBAL CIGARETTES, LIQUID NICOTINE, ELECTRONIC CIGARETTES, ROLLING PAPERS OR SMOKING PARAPHERNALIA, TO PERSONS UNDER TWENTY-ONE YEARS OF AGE IS PROHIBITED BY LAW." Such sign shall be printed on a white card in red letters at least one-half inch in height.

3. Sale of tobacco products, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes in such places, other than by a vending machine, shall be made only to an individual who demonstrates, through (a) a valid driver's license or non-driver's identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth or possession, the District of Columbia, a state government within the United States or a provincial government of the dominion of Canada, or (b) a valid passport issued by the United States government or any other country, or (c) an identification card issued by the armed forces of the United States, indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably appears to be at least twenty-five years of age, provided, however, that such appearance shall not constitute a defense in any proceeding alleging the sale of a tobacco product, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes to an individual under twenty-one years of age.

4. (a) Any person operating a place of business wherein tobacco products, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes are sold or offered for sale may perform a transaction scan as a precondition for such purchases.

(b) In any instance where the information deciphered by the transaction scan fails to match the information printed on the driver's license or non-driver identification card, or if the transaction scan indicates that the information is false or fraudulent, the attempted transaction shall be denied.

(c) In any proceeding pursuant to section thirteen hundred ninety-nine-ee of this article, it shall be an affirmative defense that

such person had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed that transaction scan, and that the tobacco product, herbal cigarettes or liquid nicotine had been sold, delivered or given to such person in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense the commissioner shall take into consideration any written policy adopted and implemented by the seller to effectuate the provisions of this chapter. Use of a transaction scan shall not excuse any person operating a place of business wherein tobacco products, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes are sold, or the agent or employee of such person, from the exercise of reasonable diligence otherwise required by this chapter. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any civil or criminal proceeding, or in any other forum.

5. A licensee or agent or employee of such licensee shall only use a device capable of deciphering any electronically readable format, and shall only use the information recorded and maintained through the use of such devices, for the purposes contained in subdivision four of this section. No licensee or agent or employee of a licensee shall resell or disseminate the information recorded during such a scan to any third person. Such prohibited resale or dissemination includes but is not limited to any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this subdivision, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes the release of such information. Each violation of this subdivision shall be punishable by a civil penalty of not more than one thousand dollars.

6. A licensee or agent or employee of such a licensee may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate this section. Such information shall be limited to the following: (a) name, (b) date of birth, (c) driver's license or non-driver identification number, and (d) expiration date. The commissioner and state commissioner of motor vehicles shall jointly promulgate any regulations necessary to govern

the recording and maintenance of these records by a licensee under this chapter. The commissioner and the state liquor authority shall jointly promulgate any regulation necessary to ensure quality control in the use of the transaction scan devices under this chapter and article five of the alcoholic beverage control law.

7. No person operating a place of business wherein tobacco products, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes are sold or offered for sale shall sell, permit to be sold, offer for sale or display for sale any tobacco product, herbal cigarettes, liquid nicotine, shisha or electronic cigarettes in any manner, unless such products and cigarettes are stored for sale (a) behind a counter in an area accessible only to the personnel of such business, or (b) in a locked container; provided, however, such restriction shall not apply to tobacco businesses, as defined in subdivision eight of section thirteen hundred ninety-nine-aa of this article, and to places to which admission is restricted to persons twenty-one years of age or older.

§ 1399-dd. Sale of tobacco products, herbal cigarettes or electronic cigarettes in vending machines. No person, firm, partnership, company or corporation shall operate a vending machine which dispenses tobacco products, herbal cigarettes or electronic cigarettes unless such machine is located: (a) in a bar as defined in subdivision one of section thirteen hundred ninety-nine-n of this chapter, or the bar area of a food service establishment with a valid, on-premises full liquor license; (b) in a private club; (c) in a tobacco business as defined in subdivision eight of section thirteen hundred ninety-nine-aa of this article; or (d) in a place of employment which has an insignificant portion of its regular workforce comprised of people under the age of twenty-one years and only in such locations that are not accessible to the general public; provided, however, that in such locations the vending machine is located in plain view and under the direct supervision and control of the person in charge of the location or his or her designated agent or employee.

§ 1399-dd-1. Public display of tobacco product and electronic cigarette advertisements and smoking paraphernalia prohibited. 1. For purposes of this section:

(a) "Advertisement" means words, pictures, photographs, symbols, graphics or visual images of any kind, or any combination thereof, which bear a health warning required by federal statute, the purpose or effect of which is to identify a brand of a tobacco product, electronic cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine, a trademark of a tobacco product, electronic cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine or a trade name associated exclusively with a tobacco product, electronic cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine or to promote the use or sale of a tobacco product, electronic cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine.

(b) "Smoking paraphernalia" means any pipe, water pipe, hookah, rolling papers, electronic cigarette, vaporizer or any other device, equipment or apparatus designed for the inhalation of tobacco or nicotine.

(c) "Vapor product" means any vapor product, as defined by section thirteen hundred ninety-nine-aa of this article, intended or reasonably expected to be used with or for the consumption of nicotine.

(d) "Tobacco products" shall have the same meaning as in subdivision five of section thirteen hundred ninety-nine-aa of this article.

(e) "Electronic cigarette" shall have the same meaning as in subdivision thirteen of section thirteen hundred ninety-nine-aa of this article.

2. (a) No person, corporation, partnership, sole proprietor, limited partnership, association or any other business entity may place, cause to be placed, maintain or to cause to be maintained, smoking paraphernalia or tobacco product, electronic cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine advertisements in a store front or exterior window or any door which is used for entry or egress by the public to the building or structure containing a place of business within one thousand five

hundred feet of a school, provided that within New York city such prohibitions shall only apply within five hundred feet of a school.

(b) Any person, corporation, partnership, sole proprietor, limited partnership, association or any other business entity in violation of this section shall be subject to a civil penalty of not more than five hundred dollars for a first violation and not more than one thousand dollars for a second or subsequent violation.

§ 1399-ee. Hearings; penalties. 1. Hearings with respect to violation of this article shall be conducted in the same manner as hearings conducted under article thirteen-E of this chapter.

2. If the enforcement officer determines after a hearing that a violation of this article has occurred, he or she shall impose a civil penalty of a minimum of three hundred dollars, but not to exceed one thousand five hundred dollars for a first violation, and a minimum of one thousand dollars, but not to exceed two thousand five hundred dollars for each subsequent violation, unless a different penalty is otherwise provided in this article. The enforcement officer shall advise the retail dealer that upon the accumulation of three or more points pursuant to this section the department of taxation and finance shall suspend the dealer's registration. If the enforcement officer determines after a hearing that a retail dealer was selling tobacco products while their registration was suspended or permanently revoked pursuant to subdivision three or four of this section, he or she shall impose a civil penalty of twenty-five hundred dollars.

3. (a) Imposition of points. If the enforcement officer determines, after a hearing, that the retail dealer violated subdivision one of section thirteen hundred ninety-nine-cc of this article with respect to a prohibited sale to a minor, he or she shall, in addition to imposing any other penalty required or permitted pursuant to this section, assign two points to the retail dealer's record where the individual who committed the violation did not hold a certificate of completion from a state certified tobacco sales training program and one point where the retail dealer demonstrates that the person who committed the violation

held a certificate of completion from a state certified tobacco sales training program.

(b) Revocation. If the enforcement officer determines, after a hearing, that a retail dealer has violated this article four times within a three year time frame he or she shall, in addition to imposing any other penalty required or permitted by this section, direct the commissioner of taxation and finance to revoke the dealer's registration for one year.

(c) Duration of points. Points assigned to a retail dealer's record shall be assessed for a period of thirty-six months beginning on the first day of the month following the assignment of points.

(d) Reinspection. Any retail dealer who is assigned points pursuant to paragraph (a) of this subdivision shall be reinspected at least two times a year by the enforcement officer until points assessed are removed from the retail dealer's record.

(e) Suspension. If the department determines that a retail dealer has accumulated three points or more, the department shall direct the commissioner of taxation and finance to suspend such dealer's registration for one year. The three points serving as the basis for a suspension shall be erased upon the completion of the one year penalty.

(f) Surcharge. A two hundred fifty dollar surcharge to be assessed for every violation will be made available to enforcement officers and shall be used solely for compliance checks to be conducted to determine compliance with this section.

4. (a) If the enforcement officer determines, after a hearing, that a retail dealer has violated this article while their registration was suspended pursuant to subdivision three of this section, he or she shall, in addition to imposing any other penalty required or permitted by this section, direct the commissioner of taxation and finance to permanently revoke the dealer's registration and not permit the dealer to obtain a new registration.

(b) If the enforcement officer determines, after a hearing, that a vending machine operator has violated this article three times within a two year period, or four or more times cumulatively he or she shall, in addition to imposing any other penalty required or permitted by this section, direct the commissioner of taxation and finance to suspend the

vendor's registration for one year and not permit the vendor to obtain a new registration for such period.

5. The department shall publish a notification of the name and address of any retailer violating the provisions of this section and indicate the number of times the dealer has violated the provisions of this section. The notification shall be published in a newspaper of general circulation in the locality in which the retailer is located.

6. (a) In any proceeding pursuant to subdivision three of this section to assign points to a retail dealer's record, the retail dealer shall be assigned one point instead of two points where the retail dealer demonstrates that the person who committed the violation of section thirteen hundred ninety-nine-cc of this article held a valid certificate of completion from a state certified tobacco sales training program.

(b) A state certified tobacco sales training program shall include instruction in the following elements:

- (1) the health effects of tobacco use, especially at a young age;
- (2) the legal purchase age and the additional requirements of section thirteen hundred ninety-nine-cc of this article;
- (3) legal forms of identification and the key features thereof;
- (4) reliance upon legal forms of identification and the right to refuse sales when acting in good faith;
- (5) means of identifying fraudulent identification of attempted underage purchasers;
- (6) techniques used to refuse a sale;
- (7) the penalties arising out of unlawful sales to underage individuals; and
- (8) the significant disciplinary action or loss of employment that may be imposed by the retail dealer for a violation of the law or a deviation from the policies of the retail dealer in respect to compliance with such law.

(c) A tobacco sales training program may be given and administered by a retail dealer duly registered under section four hundred eighty-a of the tax law which operates five or more registered locations, by a trade association whose members are registered as retail dealers, by national and regional franchisors who have granted at least five franchises in

the state to persons who are registered as such retail dealers by a cooperative corporation with five or more members who are registered as retail dealers and are operating in this state, and by a wholesaler supplying fifty or more retail dealers. A person or entity administering such training program shall issue certificates of completion to persons successfully completing such a training program. Such certificates shall be prima facie evidence of the completion of such a training program by the person named therein.

(d) A certificate of completion may be issued for a period of three years, however such certificate shall be invalidated by a change in employment.

(e) Entities authorized pursuant to paragraph (c) of this subdivision to give and administer a tobacco sales training program may submit a proposed curriculum, a facsimile of any training aids and materials, and a list of training locations to the department for review. Training aids may include the use of video, computer based instruction, printed materials and other formats deemed acceptable to the department. The department shall certify programs which provide instruction in the elements set forth in paragraph (b) of this subdivision in a clear and meaningful fashion. Programs approved by the department shall be certified for a period of three years at which time an entity may reapply for certification. A non-refundable fee in the amount of three hundred dollars shall be paid to the department with each application.

§ 1399-ff. Enforcement. 1. Where a civil penalty for a particular incident has not been imposed or an enforcement action regarding an alleged violation for a particular incident is not pending under section thirteen hundred ninety-nine-ee of this article, a parent or guardian of a person under twenty-one years of age to whom tobacco products, herbal cigarettes or electronic cigarettes are sold or distributed in violation of this article may submit a complaint to an enforcement officer setting forth the name and address of the alleged violator, the date of the alleged violation, the name and address of the complainant and the person under twenty-one years of age, and a brief statement describing the alleged violation. The enforcement officer shall notify the alleged violator by certified or registered mail, return receipt requested, that

a complaint has been submitted, and shall set a date, at least fifteen days after the mailing of such notice, for a hearing on the complaint. Such notice shall contain the information submitted by the complainant.

2. With respect to any penalty imposed with respect to a complaint under this section, an enforcement officer other than the department shall use fifty percent of such penalty collected for educational efforts administered by the board or a local school district for the purposes of preventing adolescent tobacco use.

3. The enforcement officer shall promptly notify the commissioner of taxation and finance and the director of the division of the lottery of any determination, made after a hearing, that a violation of this article has occurred together with a direction to such commissioner and director with respect to any action to be taken concerning registration under section four hundred eighty-a of the tax law and licensing under section sixteen hundred seven of the tax law.

§ 1399-gg. Out-of-package sales and minimum package sizes. 1. All tobacco cigarettes sold or offered for sale by a retail dealer shall be sold or offered for sale in the package, box, carton or other container provided by the manufacturer, importer, or packager which bears all health warnings required by applicable law.

2. No person engaged in the business of manufacturing, selling or otherwise distributing tobacco products, herbal cigarettes, cigarette wrapping papers, wrapping leaves or tubes, or any agent or employee of such person, shall manufacture or cause to be manufactured for sale in this state, or sell or distribute in this state: (a) any package or other container of cigarettes containing fewer than twenty cigarettes; (b) any package of roll-your-own tobacco containing less than six-tenths of an ounce of tobacco; or (c) any package or other container of cigarette wrapping papers, wrapping leaves or tubes, that are or are held out to be suitable for use or used as devices to wrap tobacco for smoking, containing fewer than twenty sheets, leaves or tubes.

§ 1399-hh. Tobacco and vapor product enforcement. The commissioner shall develop, plan and implement a comprehensive program to reduce the prevalence of tobacco use, and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, use particularly among persons less than twenty-one years of age. This program shall include, but not be limited to, support for enforcement of this article.

1. An enforcement officer, as defined in section thirteen hundred ninety-nine-t of this chapter, may annually, on such dates as shall be fixed by the commissioner, submit an application for such monies as are made available for such purpose. Such application shall be in such form as prescribed by the commissioner and shall include, but not be limited to, plans regarding random spot checks, including the number and types of compliance checks that will be conducted, and other activities to determine compliance with this article. Each such plan shall include an agreement to report to the commissioner: the names and addresses of tobacco retailers and vendors and vapor products dealers determined to be unlicensed, if any; the number of complaints filed against licensed tobacco retail outlets and vapor products dealers; and the names of tobacco retailers and vendors and vapor products dealers who have paid fines, or have been otherwise penalized, due to enforcement actions.

2. The commissioner shall distribute such monies as are made available for such purpose to enforcement officers and, in so doing, consider the number of licensed vapor products dealers and retail locations registered to sell tobacco products within the jurisdiction of the enforcement officer and the level of proposed activities.

3. Monies made available to enforcement officers pursuant to this section shall only be used for local tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, enforcement activities approved by the commissioner.

§ 1399-ii. Tobacco and vapor product use prevention and control

program. 1. To improve the health, quality of life, and economic well-being of all New York state citizens, there is hereby established within the department a comprehensive statewide tobacco and vapor product use prevention and control program.

2. The department shall support tobacco and vapor product use prevention and control activities including, but not limited to:

(a) Community programs to prevent and reduce tobacco use through local involvement and partnerships;

(b) School-based programs to prevent and reduce tobacco use and use of vapor products;

(c) Marketing and advertising to discourage tobacco, vapor product and liquid nicotine use;

(d) Nicotine cessation programs for youth and adults;

(e) Special projects to reduce the disparities in smoking prevalence among various populations;

(f) Restriction of youth access to tobacco products and vapor products;

(g) Surveillance of smoking and vaping rates; and

(h) Any other activities determined by the commissioner to be necessary to implement the provisions of this section.

Such programs shall be selected by the commissioner through an application process which takes into account whether a program utilizes methods recognized as effective in reducing nicotine use. Eligible applicants may include, but not be limited to, a health care provider, schools, a college or university, a local public health department, a public health organization, a health care provider organization, association or society, municipal corporation, or a professional education organization.

3. (a) There shall be established a tobacco use prevention and control advisory board to advise the commissioner on tobacco use prevention and control issues and vapor product use amongst persons less than twenty-one years of age, including methods to prevent and reduce tobacco use in the state.

(b) The board shall consist of seventeen members who shall be

appointed as follows: nine members by the governor; three members by the speaker of the assembly; three members by the temporary president of the senate and one member each by the minority leader of the senate and minority leader of the assembly. Any vacancy or subsequent appointment shall be filled in the same manner and by the same appointing authority as the original appointment. The chairperson of the board shall be designated by the governor from among the members of the board.

(c) The members shall serve for terms of two years commencing on the effective date of this section. Members of the board shall receive no compensation but shall be reimbursed for reasonable travel and other expenses incurred in the performance of their duties hereunder.

(d) The board shall meet as often as it deems necessary, but no less than four times a year. No nominee to the board shall have any past or current affiliation with the tobacco industry, vapor products industry or any industry, contractor, agent, or organization that engages in the manufacturing, marketing, distributing, or sale of tobacco products. The board shall be appointed in full within ninety days of the effective date of this section.

(e) The department shall prepare and submit to the board a spending plan for the tobacco and vapor product use prevention and control program authorized pursuant to the provisions of subdivision one of this section no later than thirty days after the submission of the budget to the legislature.

§ 1399-ii-1. Electronic cigarette and vaping prevention, awareness and control program. The commissioner shall, in consultation and collaboration with the commissioner of education, establish and develop an electronic cigarette and vaping prevention, control and awareness program within the department. Such program shall be designed to educate students, parents and school personnel about the health risks associated with vapor product use and control measures to reduce the prevalence of vaping, particularly among persons less than twenty-one years of age. Such program shall include, but not be limited to, the creation of age-appropriate instructional tools and materials that may be used by all schools, and marketing and advertising materials to discourage electronic cigarette use.

§ 1399-jj. Evaluation requirements. 1. The commissioner shall evaluate the effectiveness of the efforts by state and local governments to reduce the use of tobacco products and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, among minors and adults. The principal measurements of effectiveness shall include negative attitudes toward tobacco and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, use and reduction of tobacco and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, use among the general population, and given target populations.

2. The commissioner shall ensure that, to the extent practicable, the most current research findings regarding mechanisms to reduce and change attitudes toward tobacco and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, use are used in tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, education programs administered by the department.

3. To diminish tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, use among minors and adults, the commissioner shall ensure that, to the extent practicable, the following is achieved:

The department shall conduct an independent evaluation of the statewide tobacco use prevention and control program under section thirteen hundred ninety-nine-ii of this article. The purpose of this evaluation is to direct the most efficient allocation of state resources devoted to tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, education and cessation to accomplish the maximum prevention and reduction of tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, use among minors and adults. Such evaluation shall be provided to the governor, the majority leader of the senate and

the speaker of the assembly on or before September first, two thousand one, and annually on or before such date thereafter. The comprehensive evaluation design shall be guided by the following:

- (a) sound evaluation principles including, to the extent feasible, elements of controlled experimental methods;

- (b) an evaluation of the comparative effectiveness of individual program designs which shall be used in funding decisions and program modifications; and

- (c) an evaluation of other programs identified by state agencies, local lead agencies, and federal agencies.

§ 1399-kk. Annual tobacco and vapor product enforcement reporting. The commissioner shall submit to the governor and the legislature an interim tobacco control report and annual tobacco control reports which shall describe the extent of the use of tobacco products and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, by those under twenty-one years of age in the state and document the progress state and local governments have made in reducing such use among those under twenty-one years of age.

1. The interim tobacco control report. The commissioner shall submit to the governor and the legislature an interim tobacco control report on or before September first, nineteen hundred ninety-eight. Such interim report shall, to the extent practicable, include the following information on a county by county basis:

- (a) number of licensed and registered tobacco retailers and vendors;

- (b) the names and addresses of retailers and vendors who have paid fines, or have been otherwise penalized, due to enforcement actions;

- (c) the number of complaints filed against licensed and registered tobacco retailers;

- (d) the number of fires caused or believed to be caused by tobacco products and deaths and injuries resulting therefrom;

- (e) the number and type of compliance checks conducted; and

- (f) such other information as the commissioner deems appropriate.

2. The commissioner shall submit to the governor and the legislature

an annual tobacco and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, control report which shall describe the extent of the use of tobacco products and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, by those under twenty-one years of age in the state and document the progress state and local governments have made in reducing such use among those under twenty-one years of age. The annual report shall be submitted to the governor and the legislature on or before March thirty-first of each year beginning on March thirty-first, nineteen hundred ninety-nine. The annual report shall, to the extent practicable, include the following information on a county by county basis:

- (a) number of licensed and registered tobacco retailers and vendors and licensed vapor products dealers;

- (b) the names and addresses of retailers and vendors who have paid fines, or have been otherwise penalized, due to enforcement actions;

- (c) the number of complaints filed against licensed and registered tobacco retailers and licensed vapor products dealers;

- (d) the number of fires caused or believed to be caused by tobacco products and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine, and deaths and injuries resulting therefrom;

- (e) the number and type of compliance checks conducted;

- (f) a survey of attitudes and behaviors regarding tobacco use among those under twenty-one years of age. The initial such survey shall be deemed to constitute the baseline survey;

- (g) the number of tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, users and estimated trends in tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, use among those under twenty-one years of age;

- (h) annual tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, sales;

- (i) tax revenue collected from the sale of tobacco products and vapor products, intended or reasonably expected to be used with or for the consumption of nicotine;

- (j) the number of licensed tobacco retail outlets and licensed vapor

products dealers;

(k) the number of cigarette vending machines;

(l) the number and type of compliance checks;

(m) the names of entities that have paid fines due to enforcement actions; and

(n) the number of complaints filed against licensed tobacco retail outlets and licensed vapor products dealers.

The annual tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, control report shall, to the extent practicable, include the following information: (a) tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, control efforts sponsored by state government agencies including money spent to educate those under twenty-one years of age on the hazards of tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, use;

(b) recommendations for improving tobacco and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine, control efforts in the state; and

(c) such other information as the commissioner deems appropriate.

*** § 1399-11. Unlawful shipment or transport of cigarettes and vapor products.** 1. It shall be unlawful for any person engaged in the business of selling cigarettes to ship or cause to be shipped any cigarettes to any person in this state who is not: (a) a person licensed as a cigarette tax agent or wholesale dealer under article twenty of the tax law or registered retail dealer under section four hundred eighty-a of the tax law; (b) an export warehouse proprietor pursuant to chapter 52 of the internal revenue code or an operator of a customs bonded warehouse pursuant to section 1311 or 1555 of title 19 of the United States Code; or (c) a person who is an officer, employee or agent of the United States government, this state or a department, agency, instrumentality or political subdivision of the United States or this state and presents himself or herself as such, when such person is acting in accordance with his or her official duties. For purposes of

this subdivision, a person is a licensed or registered agent or dealer described in paragraph (a) of this subdivision if his or her name appears on a list of licensed or registered agents or dealers published by the department of taxation and finance, or if such person is licensed or registered as an agent or dealer under article twenty of the tax law.

1-a. It shall be unlawful for any person engaged in the business of selling vapor products to ship or cause to be shipped any vapor products intended or reasonably expected to be used with or for the consumption of nicotine to any person in this state who is not: (a) a person that receives a certificate of registration as a vapor products dealer under article twenty eight-C of the tax law; (b) an export warehouse proprietor pursuant to chapter 52 of the internal revenue code or an operator of a customs bonded warehouse pursuant to section 1311 or 1555 of title 19 of the United States Code; or (c) a person who is an officer, employee or agent of the United States government, this state or a department, agency, instrumentality or political subdivision of the United States or this state and presents himself or herself as such, when such person is acting in accordance with his or her official duties. For purposes of this subdivision, a person is a licensed or registered agent or dealer described in paragraph (a) of this subdivision if his or her name appears on a list of licensed or registered agents or vapor product dealers published by the department of taxation and finance, or if such person is licensed or registered as an agent or dealer under article twenty eight-C of the tax law.

2. It shall be unlawful for any common or contract carrier to knowingly transport cigarettes to any person in this state reasonably believed by such carrier to be other than a person described in paragraph (a), (b) or (c) of subdivision one of this section. For purposes of the preceding sentence, if cigarettes are transported to a home or residence, it shall be presumed that the common or contract carrier knew that such person was not a person described in paragraph (a), (b) or (c) of subdivision one of this section. It shall be unlawful for any other person to knowingly transport cigarettes to any person in this state, other than to a person described in paragraph (a), (b) or (c) of subdivision one of this section. Nothing in this subdivision

shall be construed to prohibit a person other than a common or contract carrier from transporting not more than eight hundred cigarettes at any one time to any person in this state. It shall be unlawful for any common or contract carrier to knowingly transport vapor products intended or reasonably expected to be used with or for the consumption of nicotine to any person in this state reasonably believed by such carrier to be other than a person described in paragraph (a), (b) or (c) of subdivision one-a of this section. For purposes of the preceding sentence, if vapor products intended or reasonably expected to be used with or for the consumption of nicotine are transported to a home or residence, it shall be presumed that the common or contract carrier knew that such person was not a person described in paragraph (a), (b) or (c) of subdivision one-a of this section. It shall be unlawful for any other person to knowingly transport vapor products intended or reasonably expected to be used with or for the consumption of nicotine to any person in this state, other than to a person described in paragraph (a), (b) or (c) of subdivision one of this section. Nothing in this subdivision shall be construed to prohibit a person other than a common or contract carrier from transporting vapor products, provided that the amount of vapor products intended or reasonably expected to be used with or for the consumption of nicotine shall not exceed the lesser of 500 milliliters, or a total nicotine content of 3 grams at any one time to any person in this state.

3. When a person engaged in the business of selling cigarettes ships or causes to be shipped any cigarettes to any person in this state, other than in the cigarette manufacturer's original container or wrapping, the container or wrapping must be plainly and visibly marked with the word "cigarettes". When a person engaged in the business of selling vapor products ships or causes to be shipped any vapor products intended or reasonably expected to be used with or for the consumption of nicotine to any person in this state, other than in the vapor products manufacturer's original container or wrapping, the container or wrapping must be plainly and visibly marked with the words "vapor products".

4. Whenever a police officer designated in section 1.20 of the

criminal procedure law or a peace officer designated in subdivision four of section 2.10 of such law, acting pursuant to his or her special duties, shall discover any cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine which have been or which are being shipped or transported in violation of this section, such person is hereby empowered and authorized to seize and take possession of such cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine, and such cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine shall be subject to a forfeiture action pursuant to the procedures provided for in article thirteen-A of the civil practice law and rules, as if such article specifically provided for forfeiture of cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine seized pursuant to this section as a pre-conviction forfeiture crime.

5. Any person who violates the provisions of subdivision one, one-a, or two of this section shall be guilty of a class A misdemeanor and for a second or subsequent violation shall be guilty of a class E felony. In addition to the criminal penalty, any person who violates the provisions of subdivision one, one-a, two or three of this section shall be subject to a civil penalty not to exceed the greater of (a) five thousand dollars for each such violation; (b) one hundred dollars for each pack of cigarettes shipped, caused to be shipped or transported in violation of such subdivision; or (c) one hundred dollars for each vapor product intended or reasonably expected to be used with or for the consumption of nicotine shipped, caused to be shipped or transported in violation of such subdivision.

6. The attorney general may bring an action to recover the civil penalties provided by subdivision five of this section and for such other relief as may be deemed necessary. In addition, the corporation counsel of any political subdivision that imposes a tax on cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine may bring an action to recover the civil penalties provided by subdivision five of this section and for such

other relief as may be deemed necessary with respect to any cigarettes or vapor products intended or reasonably expected to be used with or for the consumption of nicotine shipped, caused to be shipped or transported in violation of this section to any person located within such political subdivision. All civil penalties obtained in any such action shall be retained by the state or political subdivision bringing such action, provided that no person shall be required to pay civil penalties to both the state and a political subdivision with respect to the same violation of this section.

* NB There are 2 § 1399-ll's

*** § 1399-ll. Sale of bidis prohibited.** 1. No person shall knowingly sell or provide bidis to any other person. Notwithstanding that bidis is a tobacco product, no other provision of law authorizing the sale of tobacco products, other than subdivision two of this section, shall authorize the sale of bidis. Any person who violates the provisions of this subdivision shall be subject to a civil fine of not more than five hundred dollars.

2. (a) The provisions of subdivision one of this section shall not apply to a tobacco business, as defined in subdivision eight of section thirteen hundred ninety-nine-aa of this article.

(b) Any person operating a tobacco business wherein bidis is sold or offered for sale is prohibited from selling such bidis to individuals under twenty-one years of age, and shall post in a conspicuous place a sign upon which there shall be imprinted the following statement, "SALE OF BIDIS TO PERSONS UNDER TWENTY-ONE YEARS OF AGE IS PROHIBITED BY LAW." Such sign shall be printed on a white card in red letters at least one-half inch in height.

(c) Sales of bidis by a tobacco business shall be made only to an individual who demonstrates, through a driver's license or other photographic identification card issued by a government entity or educational institution indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably appears to be at least twenty-five years of age, provided, however, that such appearance shall not constitute a

defense in any proceeding alleging the sale of a tobacco product to an individual under twenty-one years of age.

(d)(i) Any person operating a tobacco business wherein bidis is sold or offered for sale may perform a transaction scan as a precondition for such purchases.

(ii) In any instance where the information deciphered by the transaction scan fails to match the information printed on the driver's license or non-driver identification card, or if the transaction scan indicates that the information is false or fraudulent, the attempted transaction shall be denied.

(iii) In any proceeding pursuant to section thirteen hundred ninety-nine-ee of this article, it shall be an affirmative defense that such person had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed that transaction scan, and that the bidis had been sold, delivered or given to such person in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense the commissioner shall take into consideration any written policy adopted and implemented by the seller to effectuate the provisions of this chapter. Use of a transaction scan shall not excuse any person operating a tobacco business wherein bidis is sold, or the agent or employee of such person, from the exercise of reasonable diligence otherwise required by this chapter. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any civil or criminal proceeding, or in any other forum.

(e) A tobacco business or agent or employee of such business shall only use a device capable of deciphering any electronically readable format, and shall only use the information recorded and maintained through the use of such devices, for the purposes contained in paragraph (d) of this subdivision. No tobacco business or agent or employee of such business shall resell or disseminate the information recorded during such a scan to any third person. Such prohibited resale or dissemination includes but is not limited to any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this paragraph, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes the release of such information. Each violation of this paragraph shall

be punishable by a civil penalty of not more than one thousand dollars.

(f) A tobacco business or agent or employee of such business may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate this section. Such information shall be limited to the following: (i) name, (ii) date of birth, (iii) driver's license or non-driver identification number, and (iv) expiration date.

(g) As used in this subdivision, "a device capable of deciphering any electronically readable format", "card holder" and "transaction scan" shall have the same meanings as are ascribed to such terms by section thirteen hundred ninety-nine-cc of this article.

* NB There are 2 § 1399-ll's

§ 1399-mm. Sale of gutka prohibited. 1. No person shall knowingly sell or provide gutka to any other person under twenty-one years of age. No other provision of law authorizing the sale of tobacco products, other than subdivision two of this section, shall authorize the sale of gutka. Any person who violates the provisions of this subdivision shall be subject to a civil penalty of not more than five hundred dollars.

2. (a) The provisions of subdivision one of this section shall not apply to a tobacco business, as defined in section thirteen hundred ninety-nine-n of this chapter.

(b) Any person operating a tobacco business wherein gutka is sold or offered for sale is prohibited from selling such gutka to individuals under twenty-one years of age, and shall post in a conspicuous place a sign upon which there shall be imprinted the following statement, "SALE OF GUTKA TO PERSONS UNDER TWENTY-ONE YEARS OF AGE IS PROHIBITED BY LAW." Such sign shall be printed on a white card in red letters at least one-half inch in height.

(c) Sales of gutka by a tobacco business shall be made only to an individual who demonstrates, through a driver's license or other photographic identification card issued by a government entity or educational institution indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably appears to be at least twenty-five years of

age, provided, however, that such appearance shall not constitute a defense in any proceeding alleging the sale of a tobacco product to an individual under twenty-one years of age.

(d) (i) Any person operating a tobacco business wherein gutka is sold or offered for sale may perform a transaction scan as a precondition for such purchases.

(ii) In any instance where the information deciphered by the transaction scan fails to match the information printed on the driver's license or non-driver identification card, or if the transaction scan indicates that the information is false or fraudulent, the attempted transaction shall be denied.

(iii) In any proceeding pursuant to section thirteen hundred ninety-nine-ee of this article, it shall be an affirmative defense that such person had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed that transaction scan, and that the gutka had been sold, delivered or given to such person in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense the commissioner shall take into consideration any written policy adopted and implemented by the seller to effectuate the provisions of this chapter. Use of a transaction scan shall not excuse any person operating a tobacco business wherein gutka is sold, or the agent or employee of such person, from the exercise of reasonable diligence otherwise required by this chapter. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any civil or criminal proceeding, or in any other forum.

(e) A tobacco business or agent or employee of such business shall only use a device capable of deciphering any electronically readable format, and shall only use the information recorded and maintained through the use of such devices, for the purposes contained in paragraph (d) of this subdivision. No tobacco business or agent or employee of such business shall resell or disseminate the information recorded during such a scan to any third person. Such prohibited resale or dissemination includes but is not limited to any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this paragraph, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes

the release of such information. Each violation of this paragraph shall be punishable by a civil penalty of not more than one thousand dollars.

(f) A tobacco business or agent or employee of such business may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate this section. Such information shall be limited to the following: (i) name, (ii) date of birth, (iii) driver's license or non-driver identification number, and (iv) expiration date.

(g) As used in this subdivision, "a device capable of deciphering any electronically readable format", "card holder" and "transaction scan" shall have the same meanings as are ascribed to such terms by section thirteen hundred ninety-nine-cc of this article.

§ 1399-mm-1. Sale of flavored products prohibited. 1. For the purposes of this section "flavored" shall mean any vapor product intended or reasonably expected to be used with or for the consumption of nicotine, with a distinguishable taste or aroma, other than the taste or aroma of tobacco, imparted either prior to or during consumption of such product or a component part thereof, including but not limited to tastes or aromas relating to any fruit, chocolate, vanilla, honey, candy, cocoa, dessert, alcoholic beverage, mint, wintergreen, menthol, herb or spice, or any concept flavor that imparts a taste or aroma that is distinguishable from tobacco flavor but may not relate to any particular known flavor. A vapor product intended or reasonably expected to be used with or for the consumption of nicotine, shall be presumed to be flavored if a product's retailer, manufacturer, or a manufacturer's agent or employee has made a statement or claim directed to consumers or the public, whether expressed or implied, that such product or device has a distinguishable taste or aroma other than the taste or aroma of tobacco.

2. No vapor products dealer, or any agent or employee of a vapor products dealer, shall sell or offer for sale at retail in the state any flavored vapor product intended or reasonably expected to be used with or for the consumption of nicotine.

3. Any vapor products dealer, or any agent or employee of a vapor products dealer, who violates the provisions of this section shall be subject to a civil penalty of not more than one hundred dollars for each individual package of flavored vapor product intended or reasonably expected to be used with or for the consumption of nicotine sold or offered for sale, provided, however, that with respect to a manufacturer, it shall be an affirmative defense to a finding of violation pursuant to this section that such sale or offer of sale, as applicable, occurred without the knowledge, consent, authorization, or involvement, direct or indirect, of such manufacturer. Violations of this section shall be enforced pursuant to section thirteen hundred ninety-nine-ff of this article, except that any person may submit a complaint to an enforcement officer that a violation of this section has occurred.

4. The provisions of this section shall not apply to any vapor products dealer, or any agent or employee of a vapor products dealer, who sells or offers for sale, or who possess with intent to sell or offer for sale, any flavored vapor product intended or reasonably expected to be used with or for the consumption of nicotine that the U.S. Food and Drug Administration has authorized to legally market as defined under 21 U.S.C. § 387j and that has received a premarket review approval order under 21 U.S.C. § 387j(c) et seq.

§ 1399-mm-2. Sale in pharmacies. 1. No tobacco product, herbal cigarette, or vapor product intended or reasonably expected to be used with or for the consumption of nicotine, shall be sold in a pharmacy or in a retail establishment that contains a pharmacy operated as a department as defined by paragraph f of subdivision two of section sixty-eight hundred eight of the education law. Provided, however, that such prohibition on the sale of tobacco products, herbal cigarettes, or vapor products intended or reasonably expected to be used with or for the consumption of nicotine, shall not apply to any other business that owns or leases premises within any building or other facility that also contains a pharmacy or a retail establishment that contains a pharmacy operated as a department as defined by paragraph f of subdivision two of

section sixty-eight hundred eight of the education law.

2. The commissioner shall have sole jurisdiction to enforce the provisions of this section. The commissioner shall have the power to assess penalties in accordance with section twelve of this chapter and pursuant to a hearing conducted in accordance with section twelve-a of this chapter. Nothing in this section shall be construed to prohibit the commissioner from commencing a proceeding for injunctive relief to compel compliance with this section.

§ 1399-mm-3. Carrier oils. 1. For the purposes of this section "carrier oils" shall mean any ingredient of a vapor product intended to control the consistency or other physical characteristics of such vapor product, to control the consistency or other physical characteristics of vapor, or to facilitate the production of vapor when such vapor product is used in an electronic cigarette. "Carrier oils" shall not include any product approved by the United States food and drug administration as a drug or medical device or manufactured and dispensed pursuant to title five-A of article thirty-three of this chapter.

2. The commissioner is authorized to promulgate rules and regulations governing the sale and distribution of carrier oils that are suspected of causing acute illness and have been identified as a chemical of concern by the United States centers for disease control and prevention. Such regulations may, to the extent deemed by the commissioner as necessary for the protection of public health, prohibit or restrict the selling, offering for sale, possessing with intent to sell, or distributing of carrier oils.

3. The provisions of this section shall not apply where preempted by federal law. Furthermore, the provisions of this section shall be severable, and if any phrase, clause, sentence, or provision is declared to be invalid, or is preempted by federal law or regulation, the validity of the remainder of this section shall not be affected thereby. If any provision of this section is declared to be inapplicable to any specific category, type, or kind of carrier oil, the provisions of this

section shall nonetheless continue to apply with respect to all other carrier oils.

*** § 1399-mmm. Sale of kratom prohibited.** 1. No person shall knowingly sell or provide kratom to any other person under twenty-one years of age. Any person who violates the provisions of this subdivision shall be subject to a civil penalty of not more than five hundred dollars.

2.(a) Any person operating a place of business wherein kratom is sold or offered for sale is prohibited from selling such kratom to individuals under twenty-one years of age, and shall post in a conspicuous place a sign upon which there shall be imprinted the following statement, "SALE OF KRATOM TO PERSONS UNDER TWENTY-ONE YEARS OF AGE IS PROHIBITED BY LAW". Such sign shall be printed on a white card in red letters at least one-half inch in height.

(b) Sales of kratom shall be made only to an individual who demonstrates, through (i) a valid driver's license or non-driver's identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth or possession, the District of Columbia, a state government within the United States or a provincial government of the dominion of Canada, or (ii) a valid passport issued by the United States government or any other country, or (iii) an identification card issued by the armed forces of the United States, or (iv) any other photographic identification card issued by a governmental entity or educational institution indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably appears to be at least twenty-five years of age, provided, however, that such appearance shall not constitute a defense in any proceeding alleging the sale of kratom to an individual under twenty-one years of age.

(c)(i) Any person operating a place of business wherein kratom is sold or offered for sale may perform a transaction scan as a precondition for such purchases.

(ii) In any instance where the information deciphered by the transaction scan fails to match the information printed on the driver's

license or non-driver identification card, or if the transaction scan indicates that the information is false or fraudulent, the attempted transaction shall be denied.

(iii) In any proceeding pursuant to section thirteen hundred ninety-nine-ee of this article, it shall be an affirmative defense that such person had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed that transaction scan, and that the kratom has been sold, delivered or given to such person in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense the commissioner shall take into consideration any written policy adopted and implemented by the seller to effectuate the provisions of this article. Use of a transaction scan shall not excuse any person operating a place of business wherein kratom is sold, or the agent or employee of such person, from the exercise of reasonable diligence otherwise required by this article. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any civil or criminal proceeding, or in any other forum.

(d) A business or agent or employee of such business shall only use a device capable of deciphering any electronically readable format, and shall only use the information recorded and maintained through the use of such devices, for the purposes contained in paragraph (c) of this subdivision. No business or agent or employee of such business shall resell or disseminate the information recorded during such a scan to any third person. Such prohibited resale or dissemination includes but is not limited to any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this subdivision, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes the release of such information. Each violation of this paragraph shall be punishable by a civil penalty of not more than one thousand dollars.

(e) A business or agent or employee of such business may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate this section. Such information shall be limited to the following: (i) name, (ii) date of birth, (iii) driver's license or non-driver identification number, and (iv) expiration date.

(f) As used in this subdivision, "a device capable of deciphering any electronically readable format", "card holder" and "transaction scan" shall have the same meanings as are ascribed to such terms by section thirteen hundred ninety-nine-cc of this article.

* NB Effective and Repealed June 17, 2026

ARTICLE 13-G
TOBACCO ESCROW FUNDS

Section 1399-nn. Findings and purpose.

1399-oo. Definitions.

1399-pp. Requirements.

§ 1399-nn. Findings and purpose. 1. Cigarette smoking presents serious public health concerns to the state and to the citizens of the state. The Surgeon General has determined that smoking causes lung cancer, heart disease and other serious diseases, and that there are hundreds of thousands of tobacco-related deaths in the United States each year. These diseases most often do not appear until many years after the person in question begins smoking.

2. Cigarette smoking also presents serious financial concerns for the state. Under certain health-care programs, the state may have a legal obligation to provide medical assistance to eligible persons for health conditions associated with cigarette smoking, and those persons may have a legal entitlement to receive such medical assistance.

3. Under these programs, the state pays millions of dollars each year to provide medical assistance for these persons for health conditions associated with cigarette smoking.

4. It is the policy of the state that financial burdens imposed on the state by cigarette smoking be borne by tobacco product manufacturers rather than by the state to the extent that such manufacturers either determine to enter into a settlement with the state or are found culpable by the courts.

5. On November twenty-third, nineteen hundred ninety-eight, leading United States tobacco product manufacturers entered into a settlement agreement, entitled the "Master Settlement Agreement," with the state. The master settlement agreement obligates these manufacturers, in return for a release of past, present and certain future claims against them as described therein, to pay substantial sums to the state (tied in part to their volume of sales); to fund a national foundation devoted to the interests of public health; and to make substantial changes in their advertising and marketing practices and corporate culture, with the intention of reducing underage smoking.

6. It would be contrary to the policy of the state if tobacco product manufacturers who determine not to enter into such a settlement could use a resulting cost advantage to derive large, short-term profits in the years before liability may arise without ensuring that the state will have an eventual source of recovery from them if they are proven to have acted culpably. It is thus in the interest of the state to require that such manufacturers establish a reserve fund to guarantee a source of compensation and to prevent such manufacturers from deriving large, short-term profits and then becoming judgment-proof before liability may arise.

§ 1399-oo. Definitions. As used in this article the following terms shall mean:

1. "Adjusted for inflation" means increased in accordance with the formula for inflation adjustment set forth in exhibit C to the master settlement agreement.

2. "Affiliate" means a person who directly or indirectly owns or controls, is owned or controlled by, or is under common ownership or control with, another person. Solely for purposes of this definition, the term "owns," "is owned" and "ownership" mean ownership of an equity interest, or the equivalent thereof, of ten percent or more, and the term "person" means an individual, partnership, committee, association,

corporation or any other organization or group of persons.

3. "Allocable share" means allocable share as that term is defined in the master settlement agreement.

4. "Cigarette" means any product that contains nicotine, is intended to be burned or heated under ordinary conditions of use, and consists of or contains: (a) any roll of tobacco wrapped in any substance not containing tobacco, or (b) tobacco, in any form, that is functional in the product, which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette; or (c) any roll of tobacco wrapped in any substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette described in paragraph (a) of this definition. The term "cigarette" includes "roll-your-own" (i.e., any tobacco which, because of its appearance, type, packaging or labeling is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes). For purposes of this definition of "cigarette," 0.09 ounces of "roll-your-own" tobacco shall constitute one individual "cigarette."

5. "Master settlement agreement" means the settlement agreement (and related documents) entered into on November twenty-third, nineteen hundred ninety-eight by the state and leading United States tobacco product manufacturers. A copy of said agreement, including any amendments thereto, shall be kept on file by the attorney general, who shall make it available for inspection and copying pursuant to the provisions of article six of the public officers law.

6. "Qualified escrow fund" means an escrow arrangement with a federally or state chartered financial institution having no affiliation with any tobacco product manufacturer and having assets of at least one billion dollars where such arrangement requires that such financial institution hold the escrowed funds' principal for the benefit of releasing parties and prohibits the tobacco product manufacturer placing

the funds into escrow from using, accessing or directing the use of the funds' principal except as consistent with paragraph (b) of subdivision two of section thirteen hundred ninety-nine-pp of this article.

7. "Released claims" means released claims as that term is defined in the master settlement agreement.

8. "Releasing parties" means releasing parties as that term is defined in the master settlement agreement.

9. "Tobacco product manufacturer" means an entity that after the effective date of this article directly (and not exclusively through any affiliate):

(a) manufacturers cigarettes anywhere that such manufacturer intends to be sold in the United States, including cigarettes intended to be sold in the United States through an importer (except where such importer is an original participating manufacturer (as that term is defined in the master settlement agreement) that will be responsible for the payments under the master settlement agreement with respect to such cigarettes as a result of the provisions of subsections II(mm) of the master settlement agreement and that pays the taxes specified in subsection II(z) of the master settlement agreement, and provided that the manufacturer of such cigarettes does not market or advertise such cigarettes in the United States);

(b) is the first purchaser anywhere for resale in the United States of cigarettes manufactured anywhere that the manufacturer does not intend to be sold in the United States; or

(c) becomes a successor of an entity described in paragraph (a) or (b) of this subdivision.

The term "tobacco product manufacturer" shall not include an affiliate of a tobacco product manufacturer unless such affiliate itself falls within any of the provisions of paragraph (a), (b) or (c) of this subdivision.

10. "Units sold" means the number of individual cigarettes sold in the state by the applicable tobacco product manufacturer (whether directly or through a distributor, retailer or similar intermediary or

intermediaries) during the year in question, as measured by excise taxes collected by the state on packs bearing the excise tax stamp of the state, or on "roll-your-own" tobacco containers. The commissioner of taxation and finance shall promulgate such regulations as are necessary to ascertain the amount of state excise tax paid on the cigarettes and roll-your-own tobacco of such tobacco product manufacturer for each year. Notwithstanding any other provision of law, a failure of a cigarette tax agent or distributor licensed pursuant to section four hundred seventy-two of the tax law to provide any information required by such regulations shall be deemed a violation of the regulations of the commissioner of taxation and finance promulgated under article twenty of the tax law. Notwithstanding any provision of law to the contrary, the commissioner of taxation and finance shall provide to the attorney general any information necessary for the administration and enforcement of this article, including: (a) returns filed in accordance with article twenty or twenty-eight of the tax law (or any other provision of the tax law providing for an excise tax on cigarettes or roll-your-own tobacco); and (b) in the event the commissioner is unable to ascertain the identity of the applicable tobacco product manufacturer with respect to particular cigarettes or roll-your-own tobacco sold in the state, the number and brand names of such cigarettes or roll-your-own tobacco, the identity of the person from whom the excise tax on such cigarettes or roll-your-own tobacco was collected, and all other available information relating to such cigarettes or roll-your-own tobacco, to be used by the attorney general to ascertain the identity of such tobacco product manufacturer and for the administration and enforcement of this article. Notwithstanding any provision of law to the contrary, the attorney general may redisclose any such information if necessary for the administration or enforcement of this article.

§ 1399-pp. Requirements. Any tobacco product manufacturer selling cigarettes to consumers within the state (whether directly or through a distributor, retailer or similar intermediary or intermediaries) after the effective date of this article shall do one of the following:

1. become a participating manufacturer (as that term is defined in

section II(jj) of the master settlement agreement) and generally perform its financial obligations under the master settlement agreement; or

2. (a) place into a qualified escrow fund by April fifteenth of the year following the year in question the following amounts (as such amounts are adjusted for inflation):

(i) 1999: \$.0094241 per unit sold after the effective date of this section;

(ii) 2000: \$.0104712 per unit sold;

(iii) for each of 2001 and 2002: \$.0136125 per unit sold;

(iv) for each of 2003 through 2006: \$.0167539 per unit sold;

(v) for each of 2007 and each year thereafter: \$.0188482 per unit sold.

(b) a tobacco product manufacturer that places funds into escrow pursuant to paragraph (a) shall receive the interest or other appreciation on such funds as earned. Such funds themselves shall be released from escrow only under the following circumstances:

(i) to pay a judgment or settlement on any released claim brought against such tobacco product manufacturer by the state or any releasing party located or residing in the state. Funds shall be released from escrow under this subparagraph: (A) in the order in which they were placed into escrow and (B) only to the extent and at the time necessary to make payments required under such judgment or settlement;

(ii) to the extent that a tobacco product manufacturer establishes that the amount it was required to place into escrow on account of units sold in the state in a particular year was greater than the master settlement agreement payments, as determined pursuant to section IX(i) of the master settlement agreement including after final determination of all adjustments, that such manufacturer would have been required to make on account of such units sold had it been a participating manufacturer, the excess shall be released from escrow and revert back to such tobacco product manufacturer; or

(iii) to the extent not released from escrow under subparagraph (i) or (ii) of this paragraph, funds shall be released from escrow and revert back to such tobacco product manufacturer twenty-five years after the date on which they were placed into escrow.

(c) Each tobacco product manufacturer that elects to place funds into

escrow pursuant to this subdivision shall annually certify to the attorney general that it is in compliance with this subdivision. The attorney general may bring a civil action on behalf of the state against any tobacco product manufacturer that fails to place into escrow the funds required under this subdivision. Any tobacco product manufacturer that fails in any year to place into escrow the funds required under this subdivision shall:

(i) be required within fifteen days to place such funds into escrow as shall bring it into compliance with this subdivision. The court, upon a finding of a violation of this subdivision, may impose a civil penalty to be paid to the general fund of the state in an amount not to exceed five percent of the amount improperly withheld from escrow per day of the violation and in a total amount not to exceed one hundred percent of the original amount improperly withheld from escrow;

(ii) in the case of a knowing violation, be required within fifteen days to place such funds into escrow as shall bring it into compliance with this subdivision. The court, upon a finding of a knowing violation of this subdivision, may impose a civil penalty to be paid to the general fund of the state in an amount not to exceed fifteen percent of the amount improperly withheld from escrow per day of the violation and in a total amount not to exceed three hundred percent of the original amount improperly withheld from escrow; and

(iii) in the case of a second knowing violation, be prohibited from selling cigarettes to consumers within the state (whether directly or through a distributor, retailer or similar intermediary) for a period not to exceed two years.

Each failure to make an annual deposit required under this subdivision shall constitute a separate violation, and the tobacco product manufacturer shall be required to pay the state's costs and attorney's fees incurred during a successful prosecution under this subdivision.

ARTICLE 13-H

REGULATION OF SHARPS

Section 1399-ss. Definitions.

1399-tt. Regulations.

1399-vv. Studies and reports.

1399-ww. Separability.

§ 1399-ss. Definitions. For the purposes of this article, unless the context clearly requires otherwise:

1. "Engineered sharps injury protection" means a physical attribute built into, or used with, a sharp that effectively reduces the risk of a sharps injury by a mechanism such as barrier creation, blunting, encapsulation, withdrawal, retraction, destruction or other mechanism.

2. "Exposure incident" means contact with blood or other potentially infectious materials that results from a sharps injury.

3. "Sharp" means any device that is or includes a needle used in the provision of health care, except for self-administration.

4. "Sharps injury" means any injury caused by a sharp, including, but not limited to, a cut, abrasion, or needlestick.

§ 1399-tt. Regulations. The commissioner shall make regulations, under this article, governing the use of sharps in health care for the purpose of: preventing sharps injuries, reducing exposure incidents, and promoting the use of safer technologies which include engineered sharps injury protections. Dentists licensed in this state, under title eight of the education law, shall be exempt from the regulations under this article. Regulations under this article shall prohibit the use of sharps that do not incorporate engineered sharps injury protections. The regulations may provide exceptions permitting the use of sharps without engineered sharps injury protections under circumstances where:

(a) appropriate engineered sharps are not available in the market;

(b) the use of sharps without engineered sharps injury protections is essential to the performance of a specific medical procedure; or

(c) based on objective product evaluation, sharps with engineered injury protections are not more effective in preventing exposure

incidents than sharps without engineered injury protections.

§ 1399-vv. Studies and reports. The commissioner shall conduct a study of exposure incidents occurring prior to and one year after the effective date of regulations made under this article to determine the effectiveness of the regulations in reducing sharps injuries and exposure incidents, the level of compliance, and the need for any modifications or revisions to the regulations. The results of the study shall be reported to the governor and the legislature no later than six months after the first twelve month period during which the regulations have been effective. The commissioner shall submit a second report no later than two years after the first report. The studies and reports under this section shall be done in consultation with the technical advisory committee established under this article.

§ 1399-ww. Separability. If any item, clause, sentence, subparagraph, subdivision, section or other part of this act, or the application thereof to any person or circumstances shall be held to be invalid, such holding shall not affect, impair or invalidate the remainder of this act, or the application of such section or part of a section held invalid, to any other person or circumstances, but shall be confined in its operation to the item, clause, sentence, subparagraph, subdivision, section or other part of this act directly involved in such holding, or to the person and circumstances therein involved.

ARTICLE 13-I

REGULATION OF SUPPLEMENTS AND OTHER PRODUCTS; DISTRIBUTION TO MINORS

Section 1399-xx. Sale or distribution of kratom products to minors.

§ 1399-xx. Sale or distribution of kratom products to minors. 1. For purposes of this section the following terms shall have the following meanings:

(a) "A device capable of deciphering any electronically readable format" or "device" shall mean any commercial device or combination of devices used at a point of sale or entry that is capable of reading the information encoded on the bar code or magnetic strip of a driver's license or non-driver identification card issued by the state commissioner of motor vehicles.

(b) "Card holder" means any person presenting a driver's license or nondriver identification card to a licensee, or to the agent or employee of such licensee under this section.

(c) "Enforcement officer" means, in a city with a population of more than one million, the department of health and mental hygiene of such city, which shall have the jurisdiction to enforce the provisions of this section in such city; and in all other counties, shall mean the department, which shall have jurisdiction to enforce the provisions of this article pursuant to rules and regulations which may be promulgated by the commissioner.

(d) "Kratom" means any part of the plant *Mitragyna speciosa* whether growing or not, and any compound, manufacture, derivative, mixture, salt or preparation of such plant or synthesized or semi-synthesized preparations of mitragynine or 7-hydroxymitragynine, their derivatives, salts, esters, and isomers.

(e) "Kratom business" means a sole proprietorship, corporation, limited liability company, partnership or other enterprise in which one of the activities is the sale, manufacture or promotion of kratom and kratom accessories, either at wholesale or retail, whether such sale, manufacture or promotion is primary or incidental, and including any agent and any employee.

(f) "Person" means a person, firm, company, corporation, partnership, sole proprietor, limited partnership or association.

(g) "Transaction scan" means the process, whether in person, online, or through any other means of communication, involving an automated bar code reader by which a licensee, or agent or employee of a licensee under this section reviews a driver's license or non-driver identification card presented as a precondition for the purchase of kratom under this section.

2. No person or kratom business shall knowingly sell or provide kratom

to any other person under twenty-one years of age.

3. (a) Any person or kratom business offering kratom for sale is prohibited from selling such kratom to individuals under twenty-one years of age, and shall post in a conspicuous place a sign upon which there shall be imprinted the following statement, "SALE OF KRATOM TO PERSONS UNDER TWENTY-ONE YEARS OF AGE IS PROHIBITED BY LAW". Such statement shall be posted in the following manner: (i) in any physical location at which such products are offered for sale, it shall be printed on a white card in red letters at least one-half inch in height and displayed as a sign, or (ii) on any website, it shall be posted in red letters in at least twelve-point font on any webpages on which such products are offered for sale, or (iii) in any mobile application, it shall be posted in red letters in at least twelve-point font on any screens on which such products are offered for sale, or (iv) in any electronic or printed materials, it shall be posted in red letters in at least twelve-point font on any pages on which such products are offered for sale.

(b) Sales of kratom shall be made only to an individual who demonstrates, through (i) a valid driver's license or non-driver's identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth or possession, the District of Columbia, a state government within the United States or a provincial government of the dominion of Canada, or (ii) a valid passport issued by the United States government or any other country, or (iii) an identification card issued by the armed forces of the United States, or (iv) any other photographic identification card issued by a governmental entity or educational institution indicating that the individual is at least twenty-one years of age. Such identification need not be required of any individual who reasonably appears to be at least twenty-five years of age, provided, however, that such appearance shall not constitute a defense in any proceeding alleging the sale of kratom to an individual under twenty-one years of age.

(c)(i) Any person or kratom business may perform a transaction scan as a precondition for such purchases.

(ii) In any instance where the information deciphered by the

transaction scan fails to match the information printed on the driver's license or non-driver identification card, or if the transaction scan indicates that the information is false or fraudulent, the attempted transaction shall be denied.

(iii) In any proceeding pursuant to subdivision five of this section, it shall be an affirmative defense that such individual had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed that transaction scan, and that the kratom has been sold, delivered or given to such individual in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense the commissioner shall take into consideration any written policy adopted and implemented by the seller to effectuate the provisions of this section. Use of a transaction scan shall not excuse any person or kratom business from the exercise of reasonable diligence otherwise required by this article. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any civil or criminal proceeding, or in any other forum.

(d) A person or kratom business shall only use a device capable of deciphering any electronically readable format, and shall only use the information recorded and maintained through the use of such devices, for the purposes contained in paragraph (c) of this subdivision. No person or kratom business shall resell or disseminate the information recorded during such a scan to any third person. Such prohibited resale or dissemination includes but is not limited to any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this subdivision, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes the release of such information. Each violation of this paragraph shall be punishable by a civil penalty of not more than one thousand dollars.

(e) A person or kratom business may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate this section. Such information shall be limited to the following: (i) name, (ii) date of birth, (iii) driver's license or non-driver identification number, and (iv) expiration date.

4. If the enforcement officer determines after a hearing that a violation of subdivision two, or paragraph (a) of subdivision three, of this section has occurred, a civil penalty may be imposed by the enforcement officer of no more than five hundred dollars, provided that each day that a person or kratom business fails to post signage required by paragraph (a) of subdivision three of this section that is identified by an enforcement officer shall be deemed a separate violation.

5. When the enforcement officer is the commissioner, the hearing shall be conducted pursuant to the provisions of section twelve-a of this chapter. When the enforcement officer is the department of health and mental hygiene, the hearing shall be conducted pursuant to procedures set forth in the county sanitary code, or health code of such city, or in the absence thereof, pursuant to procedures established by the county legislature or board of supervisors. Subsequent to any appeal having been finally determined, the commissioner may bring an action to recover the civil penalty in any court of competent jurisdiction. Nothing herein shall be construed to prohibit an enforcement officer from commencing a proceeding for injunctive relief to compel compliance with this section.

ARTICLE 14

REGULATION OF CAMPS FOR CHILDREN

Section 1400. Definitions.

1401. Disclosure statement.

1402. Delivery of disclosure statement to parent.

1403. Designation of secretary of state as agent for serving process.

1404. Penalties; failure to file disclosure statements.

1405. False and misleading statements; penalties; private rights of persons.

1406. Fees.

1407. Powers of the commissioner.

1408. Registry for children's non-regulated camps.

§ 1400. Definitions. As used in this article:

1. "Children's camp" or "camp" for the purpose of this article means any children's overnight camp, as defined in section thirteen hundred ninety-two of this chapter, children's summer day camp as defined in section thirteen hundred ninety-two of this chapter and children's traveling summer day camp as defined in section thirteen hundred ninety-two of this chapter which is located without the state and engages in any public solicitations, for deposits for, or contracts for the purpose of enrollments, or accepts or makes any contract of enrollment for any child residing in the state.

2. "Disclosure statement" means a written statement submitted initially and/or amended annually containing such information as the commissioner by regulation may require on forms to be prescribed by the commissioner. In developing such disclosure statements, the commissioner shall require any person, firm, corporation, or association operating such camp to disclose information including but not be limited to the following: (1) name and mailing address of such camp; (2) form of the business organization and principal owners, officers or directors; (3) name, address and state of incorporation, if applicable, of the owner of such camp; (4) financial stability statements; (5) the political subdivision in which such camp is located and the location of the property within that subdivision; (6) physical features of the camp including a map of the camp and such photographs as the commissioner may require; (7) provisions for sanitary and disposal facilities and water supply; (8) staffing ratios; (9) living and sleeping quarters; (10) food service facilities; (11) recreational quarters and facilities and occupancy limits; (12) insurance coverage including names and addresses of carriers; (13) emergency health services; (14) medical services; (15) results of inspections by local or state health and safety officials within the past eighteen months; and (16) any other information which the commissioner deems necessary.

3. "Short form disclosure statement" or "short form" means an abbreviated version of the disclosure statement containing such information from the disclosure statement as the commissioner may require.

4. "Parent" means the birth or adoptive parent, the guardian, or person otherwise authorized to make a contract of enrollment for a child.

§ 1401. Disclosure statement. No children's camp shall engage in any public solicitation for applications, for deposits for, or contracts for the purpose of enrollment, or advertise or cause to be advertised within the state, or otherwise solicit enrollments, or accept or make any contract of enrollment for any child residing in the state for any children's camp located without the state unless prior to such solicitation, advertisement, or acceptance of a contract or deposit for the purpose of enrollment there shall have been filed annually with the department of health a disclosure statement and a short form disclosure statement as defined in section fourteen hundred of this article. The commissioner may make provisions for amended disclosure statements.

§ 1402. Delivery of disclosure statement to parent. 1. A copy of the short form disclosure statement shall be mailed or delivered by the owner, director or other person soliciting the enrollment of a child residing within the state for any children's camp located without the state to the parent or guardian of such child. Such disclosure statement may accompany any literature or solicitation material mailed or delivered to such parent or guardian, but in no event, shall such disclosure statement be mailed or delivered to such parent or guardian later than the mailing or delivery of enrollment application forms and/or enrollment contract forms.

2. No advertisement, or other solicitation material, or enrollment application form or enrollment contract or short form, shall contain any representation that is inconsistent with any material representation or statement made in the disclosure statement or equivalent statement as last renewed or amended. Any such representation shall be deemed to be a deceptive practice pursuant to section three hundred forty-nine of the general business law.

§ 1403. Designation of secretary of state as agent for serving process. Every children's camp, operator and owner of such camp shall be deemed to have designated the secretary of state of the state of New York for service of process. Service shall be made by delivering the summons to the secretary of state or his designated representative at an office of the secretary of state within the state.

§ 1404. Penalties; failure to file disclosure statements. The attorney general may seek an injunction against any children's camp, camp owner, operator, director or officer enjoining the solicitation of enrollments for children in such camps who reside within the state of New York for failure to file a disclosure statement or repeated failure to comply with the provisions of section fourteen hundred two of this article.

§ 1405. False and misleading statements; penalties; private rights of persons. 1. Any solicitation made for the purpose of securing applications or deposits for contracts for the enrollment of a child residing in New York in a children's camp located without the state of New York shall be deemed to be advertising which if false shall be subject to the provisions of article twenty-two-A of the general business law; provided, however, that nothing contained in section three hundred fifty-e of such law shall prevent a party from seeking relief pursuant to this section.

2. Any person who has entered into a contract and enrolls a child in a children's camp located without the state of New York where a solicitation has been made by the use of a material false statement or in the failure to reveal material facts shall have the right to seek rescission of such contract and recover any moneys paid whether or not any performance has been rendered under any such contract; provided, however, that no action may be maintained if the attorney general has already commenced proceedings on behalf of such person for such relief.

3. Such relief shall be in addition to any other relief which may be sought by a party either in law or equity.

§ 1406. Fees. Upon filing the initial disclosure statement with the department, the fee shall be fifty dollars, except that no fee shall be charged in the case of camps operated by a person, firm, corporation or association for charitable, philanthropic, or religious purposes.

No filing fee shall be required for the filing of any amended disclosure statement or for the filing of subsequent disclosure statements pursuant to the annual filing requirements of section fourteen hundred one of this article.

§ 1407. Powers of the commissioner. In addition to the powers of the commissioner or the public health council to effectuate the provisions of this article, the commissioner shall have the power to:

1. Cooperate with state and federal officials to investigate the statements made in any statements or solicitation made or filed, and to promote camp safety standards.

2. Cooperate with the attorney general in the prosecution of actions under this article.

3. Maintain a file open for public inspection and answer any inquiries concerning any camp regulated by this article.

4. Establish forms and procedures to secure compliance with this article.

5. Publish a list of states which have adopted camp safety standards and a program of compliance comparable to those of New York.

§ 1408. Registry for children's non-regulated camps. The department shall establish and maintain an electronic database containing information collected pursuant to this section and section three hundred ninety-eight-f of the general business law for the purposes of providing education and outreach to children's non-regulated camps. Such database shall include the location and contact information of the children's non-regulated camp and how many children attended such camp in the prior calendar year. For establishment and maintenance of the registry, the annual fee to register shall be two hundred fifty dollars, except that no fee shall be charged in the case of a children's non-regulated camp operated by a person, firm, corporation or association for charitable, philanthropic or religious purposes.

ARTICLE 15

INSECT CONTROL

Title I. Municipal insect control (§§ 1500-1503).

II. County insect control (§§ 1520-1531).

TITLE I

MUNICIPAL INSECT CONTROL

Section 1500. Municipal insect control.

1501. Municipal mosquito control; costs to owner and municipality.

1502. Municipal mosquito control; costs; assessment on property benefited.

1503. City of New York; exceptions.

§ 1500. Municipal insect control. 1. The board of health of a municipality may take all necessary and proper steps for the control of mosquitoes, flies, black flies, punkies, ticks, and other insects detrimental to health within its jurisdiction which may require community action for the destruction or control of such insects.

2. Any accumulation of water in which mosquitoes are breeding, or are

likely to breed, is hereby declared to be a nuisance.

§ 1501. Municipal mosquito control; costs to owner and municipality.

1. Whenever the board of health of a municipality shall determine that any accumulation of water wherein mosquito larvae breed, constitutes a nuisance or a danger or injury to life or health, the owner or owners of the premises on which the breeding place is located shall bear the expense of its suppression or removal, or so much thereof as the local board of health shall determine to be equitable as hereinafter provided.

2. If the local board of health of a municipality shall determine that, owing to the natural conditions which are favorable to the breeding of mosquitoes and owing to the benefit to be secured to the public by the suppression of such conditions, a part of the expense of such suppression or removal shall be borne by the owner of such premises and a part thereof by the municipality wherein the premises are situated, such owner or occupant may proceed to suppress or remove such breeding place and shall be reimbursed by the municipality for such proportion of the reasonable expense of such suppression or removal as the board of health shall have determined should be borne by the municipality.

3. For the purpose of ascertaining the actual cost of such suppression or removal, the board of health of the municipality or its duly authorized agents may at all times have access to the premises whereon the work is being carried on; and the owner of the premises shall furnish to such board of health such information as the board of health may deem necessary or desirable for the purpose of ascertaining such actual cost.

4. If in any such case the owner of the premises shall not proceed, within a reasonable time, to suppress or remove such breeding place, the board of health of the municipality may proceed to suppress and remove the same, and for such proportion of the expense of such suppression and removal as the board of health shall have determined to be equitable, an action may be maintained against such owner, and the same shall become a

first lien upon the premises.

§ 1502. Municipal mosquito control; costs; assessment on property benefited. 1. If a local board of health of a municipality shall (a) determine, in its discretion, that, owing to the natural conditions which are favorable to the breeding of mosquitoes and owing to the benefits to be secured to the public by the suppression of such conditions, some part or all of the expenses of suppressing or removing a breeding place for mosquitoes should, in equity be borne by the owners of the property which will be benefited by such suppression; or, (b) deem it necessary, in order to suppress or remove any such breeding place, that any swamp, bog, meadow or other low or wet lands within the municipality over which said board has jurisdiction, shall be drained and that it is necessary, in order thereto, that a ditch or ditches or other channel for the free passage of water should be opened through lands belonging to a person or persons other than the owners of the lands whereon such breeding place shall be located, such local board of health shall make application to the state water power and control commission to construct and complete such channels and ditches for the free passage of water, or to do such other act or thing as such local board of health shall have determined to be necessary upon such lands in order to suppress or remove such breeding place, and to apportion, assess and collect the amount of the cost thereof from the owners of the lands which will be benefited by the suppression and removal of such breeding place.

2. The state water power and control commission shall proceed, construct and complete such channel and ditches, or do such other act or thing as may be necessary, and apportion, assess and collect the cost of the same from the owners of the lands benefited by such suppression or removal, in the manner provided for the drainage of any swamp, bog, meadow or other low or wet land and the apportionment, assessment and collection of the cost of such drainage, by the conservation law.

3. In any case where, under the provisions of this article the state water power and control commission is to determine what property is

benefited and to what extent said property is benefited by the suppression or removal of any such breeding place, such commission shall not be restricted in their determination to property immediately adjoining the premises whereon such breeding place is located; and, in apportioning the benefit to any property, such commission may consider any circumstances by reason whereon any property will be benefited by the suppression and removal of such breeding place.

4. This article shall be construed with the provisions of the conservation law. In case of conflict the provisions of this article shall be substituted for the provisions of the conservation law, but such parts of the provisions of the conservation law as are not necessarily superseded shall apply.

§ 1503. City of New York; exceptions. The provision of sections one thousand five hundred to one thousand five hundred two of this chapter, inclusive, shall not apply to the city of New York.

TITLE II

COUNTY INSECT CONTROL

Section 1520. County mosquito control commission; appointment; membership.

1521. County mosquito control commission; terms of office; oath.

1522. County mosquito control commission; compensation; expenses; officers.

1523. County mosquito control commission; legal entity.

1524. County mosquito control commission; employees; duties and compensation.

1525. County mosquito control commission; powers and duties; entry on lands.

1526. County mosquito control commission; owners' claims, damages and payments.

1527. County mosquito control commission; obstructions; interferences; violations.

1528. County mosquito control commission; estimate and approval

of annual requirements; power and duty of commissioner.
1529. County mosquito control commission; construction of law.
1530. County mosquito control commission; annual report.
1531. County mosquito control commission; regulations by board
of supervisors as to purchases, contracts and
expenditures.

§ 1520. County mosquito control commission; appointment; membership.

1. Within ten days after the presentation of a petition for the establishment of a county mosquito control commission, signed and acknowledged by two hundred residents of the county in the same manner as are deeds entitled to be recorded, the board of supervisors of a county, adjacent to a county in the state of New York which contains not more than three towns and which is adjacent to a city having a population of over three million, shall appoint a county mosquito control commission as hereinafter provided.

2. Each county mosquito control commission shall consist of

(a) four resident taxpayers of the county, to be appointed by the board of supervisors of the county duly convened by the chairman thereof for the purpose of making the said appointments; and,

(b) one member, to be appointed by the commissioner, who shall be a resident of the county for which such commission is appointed, and who shall have equal powers, privileges and duties with the other members of such commission, and who shall, in addition thereto represent the commissioner in all matters as the commissioner may direct; and,

(c) the chairman of the board of supervisors of the said county, who shall be a member ex-officio of said commission and who shall have equal powers, privileges and duties with the other members of such commission.

3. Each county mosquito control commission shall be known as "The (here shall be inserted the name of the county in and for which the commissioners are to be appointed) County Mosquito Control Commission."

4. The chairman of the board of supervisors of each county for which a county mosquito control commission is to be appointed pursuant to the

provisions of this section shall convene the said board at the most suitable and convenient place, or otherwise arrange for concerted action for the purpose of acting as a board for the appointment of the four resident taxpayers in such county, as herein provided. The members of such appointing board shall serve without pay, except that the necessary expenses of each member for actual attendance at any meeting of such board shall be allowed and paid.

§ 1521. County mosquito control commission; terms of office; oath. 1. The terms of office of all members of each county mosquito control commission, appointed after the expiration of the first appointment, shall be four years.

2. The members first appointed to the county mosquito control commission by the county board of supervisors in any district under the provisions of this article shall hold office respectively for the term of one, two, three and four years.

3. The term of the member appointed by the commissioner shall be four years.

4. Vacancies in such commission occurring by resignation or otherwise, shall be filled by the county board of supervisors in the manner provided in section one thousand five hundred twenty of this chapter, except any vacancy caused by resignation or otherwise of the member appointed by the commissioner shall be filled by the commissioner in the manner provided in section one thousand five hundred twenty of this chapter, and the persons so appointed to fill such vacancies shall be appointed for the unexpired term only.

5. Before entering upon the duties of his office each commission member shall take and subscribe an oath or affirmation before the clerk of the county in which is situated the district in and for which he is appointed to perform faithfully and impartially the duties of his office, which oath or affirmation shall be filed with such clerk.

§ 1522. County mosquito control commission; compensation; expenses; officers. 1. All members of a county mosquito control commission shall serve without compensation, except that the necessary expenses of each member for actual attendance at meetings of such commission shall be allowed and paid.

2. Such commission shall annually choose from among its members a president and a treasurer, who shall serve without pay, and they shall respectively perform the duties usually performed by persons holding such offices.

3. Such commission may appoint a secretary, whose compensation shall be fixed by the commission, by and with the approval of the board of supervisors.

4. No person employed by such commission shall be a member thereof.

§ 1523. County mosquito control commission; legal entity. From and after the appointment, qualification and organization of its members the county mosquito control commission shall become and be a body corporate and politic, under the name given in such petition, and by such name and style may sue, be sued, execute contracts, have a corporate seal, and shall have all powers herein conferred upon it within the county wherein it is appointed.

§ 1524. County mosquito control commission; employees; duties and compensation. 1. Each county mosquito control commission, may, with the approval of the board of supervisors of the county, appoint and employ such clerks, assistants, inspectors and day laborers as may be necessary to carry out the provisions of this article.

2. The compensation of such employees shall be fixed by the board of supervisors of the county.

3. The commission shall prescribe the duties and hours of employment of clerks and assistants and make all rules and regulations respecting the same and furnish them with necessary and proper facilities.

§ 1525. County mosquito control commission; powers and duties; entry on lands. 1. Each county mosquito control commission shall use every means feasible and practicable to suppress mosquitoes, ticks, flies and other hominoxious arthropods of every kind requiring community action for their control, and which may be found within the county for which such commission is appointed.

2. Such commission shall have power and authority to enter without hinderance upon any or all lands within the county for the purpose of draining or treating the same and to perform all other acts which in its opinion and judgment may be necessary and proper for the elimination of mosquitoes or other hominoxious arthropods which may require community action for their control, and which may be found within such counties, but such measures shall not be injurious to wild life.

3. Before entering upon any such lands for such purposes as outlined under this section, the commission shall publish each year at least once during the year, immediately following the approval of the board of supervisors of its plans for work during the ensuing year as provided in this article, in at least one newspaper in every town of the county where work is to be performed and in which such a paper is published, a general description of the land where the work is to be performed, and in case of a town where work is to be performed by the commission and in which no newspaper is published, individual notices shall be first sent to every owner in such town upon whose land the commission proposes to enter for said purposes if the name of such owner be known; if unknown such notice shall be posted in not less than five conspicuous places in such town.

§ 1526. County mosquito control commission; owners' claims, damages and payments. 1. Any person objecting to or who is aggrieved or who

claims damages due to the execution of the work of the commission, shall file a protest with the commission setting forth his grievance or claim. The commission shall thereupon and within thirty days after the filing of such protest or claim, set a day for a public hearing thereof. In all such cases the decision of the commission as to the necessity of such work shall be final.

2. Any damage claimed by any party on account of entry work of the commission upon his property shall be determined by an action in court to be tried in the county; and the amount of any damage that may be awarded such party shall be included in the next succeeding estimate of annual requirements of the commission and shall be included in the annual tax levy as provided for in this article, and be paid by the commission.

§ 1527. County mosquito control commission; obstructions; interferences; violations. Any person who obstructs or interferes with the entry of the county mosquito control commission or its employees upon land, or who obstructs or interferes with, molests, or damages any of the work performed by the said commission shall be guilty of a misdemeanor.

§ 1528. County mosquito control commission; estimate and approval of annual requirements; power and duty of commissioner. 1. Each county mosquito control commission shall, on or before the first day of October in each year, file with the commissioner and with the board of supervisors of its county, a detailed estimate of the moneys required for the ensuing year and a plan of the work to be done and the methods to be employed, together with a general description of such lands.

2. The board of supervisors shall have power to approve, modify or alter such estimates, plans and methods, and it shall be the duty of the board of supervisors in the county in which a commission is appointed at its annual or other meeting held in the month of October of each year and on receipt of the said report from the county commission, to cause

to be included in the annual budget of such county for the succeeding year the amount of money included in such estimate of moneys, as approved, modified or altered by it for the use and purposes of the mosquito control commission, in its said county.

3. Provided, however, that any district which at the time when this section, as hereby amended, take effect, shall have been legally established under chapter two hundred forty-six of the laws of nineteen hundred sixteen, as amended by chapter thirteen of the laws of nineteen hundred twenty-six, shall be exempted from the provisions of this chapter and from taxation under it.

4. The county treasurer of such county shall pay from time to time to the mosquito control commission, on the requisition of such commission, duly signed and approved by the president and secretary thereof such sums as may be needed within the appropriation.

§ 1529. County mosquito control commission; construction of law.

Nothing in this article shall be construed to alter, amend, modify or repeal any of the provisions of article thirteen of this chapter, or any of the provisions of the conservation law except to the extent that the provisions of this article are inconsistent therewith.

§ 1530. County mosquito control commission; annual report. It shall be the duty of each county mosquito control commission, on or before the first day of September in each year, to submit to the commissioner and to the board of supervisors in the county comprised within a mosquito control district, a report setting forth the amount of moneys expended during the previous year showing each item of expenditure, the methods employed, the work accomplished and any other information which in its judgment may seem pertinent, or which the board of supervisors may demand.

§ 1531. County mosquito control commission; regulations by board of

supervisors as to purchases, contracts and expenditures. Such mosquito extermination commission shall not pay any accounts or claims, make any contracts or expenditures or purchase any materials, supplies or equipment except after compliance with such regulations as may be adopted by the board of supervisors with respect to audit, advertising or otherwise.

ARTICLE 16

PESTICIDE CONTROL BOARD

Section 1601. Legislative findings and purpose.

1602. Definition.

1603. Creation of pesticide control board.

1604. Organization of pesticide control board.

1605. Meetings.

1606. Functions, powers and duties.

1607. Cooperation with other departments.

1608. Loans and grants.

1609. Conflicting laws.

§ 1601. Legislative findings and purpose. Pesticides have proved valuable in the control of harmful insects, weeds, fungi and other forms of plant and animal life. When used indiscriminately, however, they may injure crops, whether or not directly treated, contaminate the air, soil and water, thus upsetting the desired ecological balance, and harm humans, fish and wildlife by direct poisoning or by gradual accumulation of pesticide residues in tissues. It is the purpose of this article better to protect the public health and welfare and to minimize the potential pesticide hazard to man and his environment, consistent with the public interest in the benefits to be derived from their safe and scientific application, by establishing a pesticide control board to formulate over-all policy in the state's regulatory programs and coordinate state efforts to control the use of pesticides.

§ 1602. Definition. When used in this article, the term "pesticide"

means any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating any insect, rodent, fungi, weeds, or other forms of plant or animal life or viruses, except viruses on or in living man or animals.

§ 1603. Creation of pesticide control board. 1. There is hereby created within the department of health a pesticide control board. Such board shall have seven voting members, who shall be the commissioners of agriculture and markets, commerce, conservation, education and health, the industrial commissioner and the commissioner of transportation. In addition, as advisory members, there shall be the dean of the New York state college of agriculture at Cornell university, the dean of the New York state college of forestry at Syracuse university, the dean of the New York state veterinary college, the director of the New York state agricultural experiment station at Geneva, and, to be appointed by the governor, six members at least one of whom shall be the dean of a state university college of medicine, one an ecologist, one a representative of the pesticide manufacturing industry, one a representative of custom applicators of pesticides and one a representative of organized conservationists.

2. Advisory members appointed by the governor shall serve for terms of three years, such terms to commence on July first and to expire on June thirtieth; provided, however, that of the advisory members first appointed, two shall be appointed for a one year term expiring on June thirtieth, nineteen hundred sixty-five, and two shall be appointed for a two year term expiring on June thirtieth, nineteen hundred sixty-six. Each such advisory member shall hold office until his successor shall have been appointed and qualified.

3. Each voting member and each ex-officio advisory member of such board may, by official order filed in the office of the board, designate a deputy or other representative in his department to perform his duties under this article, except as provided in subdivision one of section sixteen hundred six of this article.

4. The members of the board or their respective designees shall receive no additional compensation for their services as members of the board, but shall be allowed their actual and necessary expenses incurred in the performance of their duties under this article.

§ 1604. Organization of pesticide control board. 1. The chairman of the board shall be the commissioner of health.

2. The board shall appoint an executive secretary who shall act as the administrative agent of the board, keep a record of all meetings of the board and perform such other functions and duties as the board may direct.

3. The board may make and adopt by-laws to regulate its proceedings.

§ 1605. Meetings. 1. The board shall meet at least once every three months. Special meetings shall be called by the chairman on his own initiative or upon the written request of two voting members. Ten days' written notice of the time, place and purpose of each meeting shall be given to each member of the board.

2. Four voting members of the board shall constitute a quorum to transact the business of the board. A majority vote shall be necessary for any action taken by the board except as provided in subdivision one of section sixteen hundred six of this article.

§ 1606. Functions, powers and duties. 1. The board (a) may prepare and recommend rules and regulations, or amendment or repeal thereof, for controlling the use, transportation, storage and disposal of pesticides consistent with the declared purpose of this article and (b) shall designate the department or departments by whom such rules or regulations shall be promulgated, administered and enforced in accordance with the functions, powers and duties of such department or departments prescribed by law. Such rules and regulations shall not be

effective until filed in the office of the department of state. Any such action shall be taken only at a meeting upon the affirmative vote in person or by mail of at least five voting members of the board, exclusive of any deputy or other representative, after a meeting with the advisory members of the board and consideration of available scientific evidence.

2. To further the declared purpose of this article, the board shall have the following functions, powers and duties:

(a) To formulate over-all policy in the state's programs for regulating the use, transportation, storage and disposal of pesticides.

(b) To coordinate the activities and programs of member departments concerned with the use and effects of pesticides.

(c) To cause such studies, research and investigations to be made as it may deem advisable and necessary.

(d) To hold public hearings.

(e) To collect and compile information and data relating to the use and effects of pesticides.

(f) To advise and assist state departments and agencies upon request.

(g) To inform the public concerning the state's efforts to regulate the use of pesticides and to provide information concerning pesticides.

(i) To recommend that the use of specific pesticides be prohibited under specified conditions.

(j) To consult and cooperate with the appropriate agencies of the federal government or of other states to more effectively carry out its functions, powers and duties hereunder.

(k) To do all things necessary or reasonable to carry out the foregoing functions, powers and duties.

§ 1607. Cooperation with other departments. The board may request from any department, division, board, bureau, commission or other agency of the state, and the same are authorized to provide, without additional compensation, such assistance, services and data as may be necessary to carry out the purpose of this article. The board may, within appropriations available therefor, employ such other personnel as may be necessary to carry out its responsibilities under this article.

§ 1608. Loans and grants. The board shall have the power to accept and administer loans and grants from the federal government and other sources, public or private, for carrying out its functions under this article.

§ 1609. Conflicting laws. Nothing in this article shall be deemed to derogate or detract from the functions, powers and duties of any department or agency of the state prescribed by law.

ARTICLE 17

INGREDIENT DISCLOSURES FOR VAPOR PRODUCTS AND E-CIGARETTES

Section 1700. Definitions.

1701. Disclosure.

1702. Penalties.

§ 1700. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Vapor products" shall mean any vapor product, as defined by section thirteen hundred ninety-nine-aa of this chapter, intended or reasonably expected to be used with or for the consumption of nicotine.

2. "Electronic cigarette" or "e-cigarette" shall have the same meaning as defined by section thirteen hundred ninety-nine-aa of this chapter.

3. "Ingredient" shall mean all of the following:

(a) any intentional additive present in any quantity in a vapor product;

(b) a byproduct or contaminant, present in a vapor product in any quantity equal to or greater than one-half of one percent of the content of such product by weight, or other amount determined by the

commissioner;

(c) a byproduct present in a vapor product in any quantity less than one-half of one percent of the content of such product by weight, provided such element or compound has been published as a chemical of concern on one or more lists identified by the commissioner; and

(d) a contaminant present in a vapor product in a quantity determined by the commissioner and less than one-half of one percent of the content of such product by weight, provided such element or compound has been published as a chemical of concern on one or more lists identified by the commissioner.

4. "Intentionally added ingredient" shall mean any element or compound that a manufacturer has intentionally added to a vapor product at any point in such product's supply chain, or at any point in the supply chain of any raw material or ingredient used to manufacture such product.

5. "Byproduct" shall mean any element or compound in the finished vapor product, or in the vapor produced during consumption of a vapor product, which: (a) was created or formed during the manufacturing process as an intentional or unintentional consequence of such manufacturing process at any point in such product's supply chain, or at any point in the supply chain of any raw material or ingredient used to manufacture such product; or (b) is created or formed as an intentional or unintentional consequence of the use of an e-cigarette or consumption of a vapor product. "Byproduct" shall include, but is not limited to, an unreacted raw material, a breakdown product of an intentionally added ingredient, a breakdown product of any component part of an e-cigarette, or a derivative of the manufacturing process.

6. "Contaminant" shall mean any element or compound made present in a vapor product as an unintentional consequence of manufacturing. Contaminants include, but are not limited to, elements or compounds present in the environment which were introduced into a product, a raw material, or a product ingredient as a result of the use of an environmental medium, such as naturally occurring water, or other materials used in the manufacturing process at any point in a product's

supply chain, or at any point in the supply chain of any raw material or ingredient used to manufacture such product.

7. "Manufacturer" shall mean any person, firm, association, partnership, limited liability company, or corporation which produces, prepares, formulates, or compounds a vapor product or e-cigarette, or whose brand name is affixed to such product. In the case of a vapor product or e-cigarette imported into the United States, "manufacturer" shall mean the importer or first domestic distributor of such product if the entity that manufactures such product or whose brand name is affixed to such product does not have a presence in the United States.

§ 1701. Disclosure. 1. Manufacturers of vapor products or e-cigarettes distributed, sold, or offered for sale in this state, whether at retail or wholesale, shall furnish to the commissioner for public record and post on such manufacturer's website, in a manner prescribed by the commissioner that is readily accessible to the public and machine readable, information regarding such products pursuant to rules or regulations which shall be promulgated by the commissioner.

(a) For each vapor product, the information posted pursuant to this subdivision shall include, but shall not be limited to:

(i) a list naming each ingredient of such vapor product in descending order of predominance by weight in such product, except that ingredients present at a weight below one percent may be listed following other ingredients without respect to the order of predominance by weight;

(ii) the nature and extent of investigations and research performed by or for the manufacturer concerning the effects on human health of such product or its ingredients;

(iii) where applicable, a statement disclosing that an ingredient of such product is published as a chemical of concern on one or more lists identified by the commissioner; and

(iv) for each ingredient published as a chemical of concern on one or more lists identified by the commissioner, an evaluation of the availability of potential alternatives and potential hazards posed by such alternatives.

(b) For each e-cigarette the information posted pursuant to this

subdivision shall include, but shall not be limited to:

(i) a list naming any toxic metal, including but not limited to lead, manganese, nickel, chromium, or zinc, as a constituent of any heating element included in such e-cigarette;

(ii) a list naming each byproduct that may be introduced into vapor produced during the normal use of such e-cigarette;

(iii) the nature and extent of investigations and research performed by or for the manufacturer concerning the effects on human health of such product or such ingredients;

(iv) where applicable, a statement disclosing that an ingredient is published as a chemical of concern on one or more lists identified by the commissioner; and

(v) for each constituent of any heating element identified as a toxic metal and ingredient published as a chemical of concern on one or more lists identified by the commissioner, an evaluation of the availability of potential alternatives and potential hazards posed by such alternatives.

2. Manufacturers shall furnish the information required to be posted pursuant to subdivision one of this section on or before January first, two thousand twenty-one, and every two years thereafter. In addition, such manufacturers shall furnish such information prior to the sale of any new vapor product or e-cigarette, when the formulation of a currently disclosed product is changed such that the predominance of the ingredients in such product is changed, when any list of chemicals of concern identified by the commissioner pursuant to this article is changed to include an ingredient present in a vapor product or e-cigarette subject to this article, or at such other times as may be required by the commissioner.

3. The information required to be posted pursuant to subdivision one of this section shall be made available to the public by the commissioner and manufacturers, in accordance with this section, with the exception of those portions which a manufacturer determines, subject to the approval of the commissioner, are related to a proprietary process the disclosure of which would compromise such manufacturer's competitive position. The commissioner shall not approve any exceptions

under this subdivision with respect to any ingredient published as a chemical of concern on one or more lists identified by the commissioner.

§ 1702. Penalties. Notwithstanding any other provision of this chapter, any manufacturer who violates any of the provisions of, or who fails to perform any duty imposed by, this article or any rule or regulation promulgated thereunder, shall be liable, in the case of a first violation, for a civil penalty not to exceed five thousand dollars. In the case of a second or any subsequent violation, the liability shall be for a civil penalty not to exceed ten thousand dollars for each such violation.

ARTICLE 20

REPORTING OF ALZHEIMER'S DISEASE

- Section 2000. Definition.
- 2001. Physicians and facilities; duty to report.
 - 2002. Contents of report.
 - 2003. Duties of department.
 - 2004. Duties of commissioner.
 - 2004-a. Coordinating council for services related to Alzheimer's disease and other dementia.

§ 2000. Definition. As used in this article, "facility" shall mean any governmental or private agency, department, institution, clinic, laboratory, hospital, nursing care facility, health maintenance organization, association or other similar entity that provides medical care.

§ 2001. Physicians and facilities; duty to report. An attending physician or a person representing or employed by a facility as defined by the commissioner shall report the existence of Alzheimer's disease to the department when the physician or other person diagnoses or confirms the presence of that illness.

§ 2002. Contents of report. The report as set forth in section two thousand one of this article shall be designated an Alzheimer's disease report and shall contain information which the commissioner establishes as necessary to identify, locate and investigate the occurrence, frequency, incidence, cause, effect and prognosis of Alzheimer's disease, and other relevant data and findings with respect thereto.

§ 2003. Duties of department. 1. Alzheimer's disease reports and data shall be maintained by the department in a manner suitable for research purposes, and shall be made available to persons as set forth in subdivision two of this section.

2. Notwithstanding any inconsistent provision of law, all information collected pursuant to this article shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes as provided in this article. Access to the information shall be limited to the authorized employees of the department and persons with a valid scientific interest and qualifications, as defined by the commissioner, who are engaged in demographic, epidemiological or other similar studies related to health, and who agree, in writing, to maintain confidentiality as established by the commissioner.

3. The department shall maintain an accurate record of all persons who are given access to the information contained in the Alzheimer's disease reports. The record shall include the name of the person authorizing access, the name, title and organizational affiliation of persons given access, dates of access, and the specific purpose for which information is to be used. The record of access shall be open to public inspection during normal operating hours of the department.

4. Any person who, in violation of a written agreement to maintain confidentiality, discloses any information provided pursuant to this section, or who uses information provided pursuant to this section in a manner other than that prescribed by the commissioner, may be denied

further access to any confidential information maintained by the department.

§ 2004. Duties of commissioner. The commissioner shall promulgate rules and regulations to implement the provisions of this article, including but not limited to:

1. defining a person representing or employed by a facility and defining a person with a valid scientific interest;
2. establishing the form, content and manner of filing the Alzheimer's disease report;
3. prescribing the permissible uses for the information made available pursuant to this article; and
4. establishing procedures to maintain the confidentiality of information provided to persons pursuant to this article.

§ 2004-a. Coordinating council for services related to Alzheimer's disease and other dementia. 1. There is hereby created in the department of health a coordinating council for services related to Alzheimer's disease and other dementia, to facilitate interagency planning and policy, review specific agency initiatives for their impact on services related to the care of persons with dementia and their families, and provide a continuing forum for concerns and discussion related to the formulation of a comprehensive state policy relating to Alzheimer's disease and services for persons with incurable dementia.

2. The council shall be comprised of twenty-one members as follows: the commissioner of health, the director of the state office for the aging, the commissioner of children and family services, the commissioner of education, the commissioner of mental health and the commissioner of the office for people with developmental disabilities who shall serve ex officio and who may designate representatives to act

on their behalf. The governor shall appoint seven other members with expertise in Alzheimer's disease, other dementia or elder care issues, at least two of whom shall represent not-for-profit corporations whose primary purpose is to provide access to experts in the care of persons with Alzheimer's disease and related dementia, that are part of a statewide network of not-for-profit corporations established specifically to respond at the local and regional level to the needs of this population and that provide family intervention services related to Alzheimer's disease in order to postpone or prevent nursing home placements of individuals with Alzheimer's disease or other dementia. Eight members shall be appointed by the governor on the recommendation of the legislative leaders as follows: the temporary president of the senate and the speaker of the assembly shall each recommend three members to the council. One of the three members recommended by the temporary president and one of the three members recommended by the speaker shall be a clinical or research expert in the field of dementia and one of the three members appointed by each shall be a family member or caregiver of a person suffering from Alzheimer's disease or other dementia. One member shall be appointed on the recommendation of the minority leader of the senate and one member shall be appointed on the recommendation of the minority leader of the assembly. The commissioner of health and the director of the office for the aging shall serve, ex officio, as co-chairs of the council. Administrative duties shall be the responsibility of the department. The members of the council shall receive no compensation for their services.

3. Within one year after the effective date of this section, the council shall establish community forums to gain input from consumers, providers, key researchers in the field and other interested parties to provide input and direction on developing a New York state plan for the identification and treatment of Alzheimer's disease in the community. A community forum shall be established in each of the following regions of the state: Long Island, New York city, Northern Metropolitan New York, Northeastern New York, Utica area, Central New York, Rochester area and Western New York. Such state plan shall include but not be limited to identifying best practices in working with persons with Alzheimer's disease, best interventions for caregivers to help reduce caregiver

burnout, best approaches to training doctors, nurses and other medical and non-medical professionals and paraprofessionals to identify Alzheimer's disease, a community assessment of strengths and gaps in community support services, ways in which to coordinate services among various systems, different financing approaches to pay for community support services and any other recommendations.

4. (a) The council shall meet quarterly or more frequently if its business shall require. The community forums in the first year of implementation count as a formal meeting of the council. The members of the council shall receive no compensation but shall be reimbursed for travel and other expenses actually and necessarily incurred in the performance of their duties. The council shall provide reports to the governor and the legislature on or before June thirtieth, two thousand nine and by June thirtieth of every other year thereafter. Such reports shall include recommendations for state policy relating to dementia and a review of services initiated and coordinated among public and private agencies to meet the needs of persons with Alzheimer's disease and other dementia and their families.

(b) The council shall additionally review and report upon the use of clinically recognized, scientifically based, cognitive impairment screening tools used to identify signs of and individuals at-risk for cognitive impairment, including Alzheimer's disease or other dementias, in all settings of the health continuum. Such tools shall include but not be limited to tools approved and/or recognized by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), and others as determined by the council which are used by health care providers, across all settings of the health continuum. The council shall also review and report on best practices of providers concerning early identification of at-risk individuals and referral practices, the range of interventions and services available for the cognitively impaired, and shall report its assessment of the need and presence of such tools and practices in each sector of the health continuum. The council shall further include in its reports any findings concerning potential gaps of identification and intervention for the cognitively impaired, the need for public education about

cognitive impairment, and recommendations to address that education need.

5. The department shall serve as the focal point to develop comprehensive coordinated responses of the various state agencies with regard to Alzheimer's disease and related dementia and thus help to assure timely and appropriate responses to issues and problems. The department shall collaborate with the state office for the aging on issues related to nonmedical support services for individuals with Alzheimer's disease and other dementia and their caregivers. The department shall collaborate with other appropriate state agencies to establish a simplified coordinated assessment procedure for obtaining needed services for persons with Alzheimer's disease and other dementia.

6. The department, in consultation with the council, shall utilize data and information compiled and maintained pursuant to this article to coordinate state funded research efforts to ensure the most efficient use of funds available for this purpose.

ARTICLE 20-A

ALZHEIMER'S COMMUNITY ASSISTANCE PROGRAM

Section 2005. Legislative intent.

2006. Grants.

2007. Services to be provided.

2008. Apportionment.

2009. Availability of funds.

§ 2005. Legislative intent. 1. The legislature finds that Alzheimer's disease and related dementing illnesses which destroy certain vital cells in the brain, currently affect more than four hundred thousand New Yorkers. Although these diseases are not limited to the elderly, medical researchers have projected that Alzheimer's disease and related diseases of the brain will show a significant increase in numbers to coincide with the growth in the population of the elderly. Because of the inability of persons with Alzheimer's and related dementias to live in

safety or undertake even the simplest tasks of daily living without cueing, assistance and/or supervision, this population requires a high level of care throughout the moderate and advanced stages of the disease. The reconfiguration of the health care delivery system currently underway necessitates special recognition of this patient population which often, while sometimes otherwise physically healthy, demands this high level of care because of their cognitive impairment and other dementia symptoms.

2. In response to the needs of New York state's Alzheimer's community, and stemming from within this community, a statewide network of not-for-profit corporations have been established, dedicated specifically to responding at the local level to the needs of this community. This network provides important support and educational services to caregivers of persons with Alzheimer's disease. Eighty percent of all Alzheimer's care is provided at home and/or in the community, and is delivered by family caregivers. By supporting family caregivers and informal supports at home and in the community, costly institutionalization can be significantly delayed or avoided altogether. This results in a more effective utilization of resources. It is the intent of the legislature to encourage and foster such home and community-based assistance through this existing network of not-for-profit corporations. It is further important in this time of changing resources and resource allocation, to encourage this network to work closely with the department to ensure that the Alzheimer's community is appropriately educated and included with respect to all available health care options.

§ 2006. Grants. Subject to amounts expressly appropriated therefor, the commissioner is authorized to award grants to applicants approved by the department for the Alzheimer's Community Assistance Program (ACAP) which is hereby established within the department. Applicants shall be limited to not-for-profit corporations which have as their primary purpose providing family intervention services related to Alzheimer's disease, which are designed to postpone or prevent nursing home placements on a statewide basis.

§ 2007. Services to be provided. The Alzheimer's Community Assistance Program shall undertake the following services:

1. To establish and operate self-help support groups for family members of persons with Alzheimer's disease residing at home.
2. To provide training programs and support services for volunteers, family members, and/or home health care workers enabling them to deliver proper care for persons with Alzheimer's who reside at home and in the community.
3. To assist in the development of day care programs and other suitable respite services which will provide congregate care for persons with Alzheimer's.
4. To recruit, train and supervise volunteers who will provide in and out-of-home respite care services to support family caregivers.
5. To work with the department to distribute educational materials regarding community resources and care options, including managed care as it becomes available for persons with Alzheimer's disease.
6. To undertake outreach to families with a member suffering from Alzheimer's to participate in counseling, education and support.
7. To work with the department of health to explore delivery mechanisms for family intervention services to delay institutionalization.

§ 2008. Apportionment. Grants awarded pursuant to this article in any given fiscal year shall be apportioned out of the total funds appropriated for this purpose, to applicants based on the size of the Alzheimer's community served in proportion to the monies available as determined by the department. All qualified applicants shall be

entitled to a grant on the foregoing basis unless an applicant is receiving funding through the Alzheimer's Community Assistance Program.

§ 2009. Availability of funds. The funds appropriated pursuant to this article for services and expenses of the Alzheimer's Community Assistance Program (ACAP) to serve persons with Alzheimer's disease and their caregivers shall be made available to the commissioner for expenses incurred in carrying out the provisions of this article. Such monies shall be payable on the audit and warrant of the comptroller on vouchers certified in the manner prescribed by law.

ARTICLE 20-B

STATE PARKINSON'S DISEASE REGISTRY

Section 2010. Definitions.

2011. Duty to report.

2012. Establishment of registry.

2013. Duties of the department.

2014. Duties of the commissioner.

§ 2010. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Parkinson's disease" means a chronic and progressive neurologic disorder resulting from deficiency of the neurotransmitter dopamine as the consequence of specific degenerative changes in the area of the brain called the basal ganglia.

2. "Parkinsonisms" means related conditions that cause a combination of the movement abnormalities seen in Parkinson's disease including, but not limited to, tremor at rest, slow movement, muscle rigidity, impaired speech, or muscle stiffness, which often overlap with and can evolve from what appears to be Parkinson's disease.

§ 2011. Duty to report. 1. Every physician, nurse practitioner, physician assistant and general hospital that diagnoses or is treating a patient diagnosed with Parkinson's disease or Parkinsonisms, shall give notice no later than one hundred eighty days of every case of Parkinson's disease coming under their care, to the department, in a format to be determined by the commissioner, except as otherwise provided in this article.

2. All patients diagnosed with Parkinson's disease or Parkinsonisms shall be provided written and verbal notice regarding the collection of information and patient data on Parkinson's disease. Patients who do not wish to participate in the collection of data shall affirmatively opt-out in writing after ample opportunity to review such notice, provided that, the mere incidence of a patient with Parkinson's disease shall be the sole required information for the registry under section two thousand twelve of this article for any patient who chooses not to participate.

§ 2012. Establishment of registry. 1. The department shall establish a Parkinson's disease registry for the collection of information on the incidence and prevalence of Parkinson's disease and Parkinsonisms. The department may consult with Parkinson's disease experts, including neurologists, patients living with Parkinson's disease, and Parkinson's disease researchers to assist in the development and implementation of such registry, and to determine what data shall be collected.

2. All information maintained by the department under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

3. The department may enter into an agreement to provide data collected in the Parkinson's disease registry to the federal Centers for Disease Control and Prevention, or successor agency, to local health officers, or health researchers for the study of Parkinson's disease for public health and research purposes. Data shall be provided in summary,

statistical, aggregate, or other form such that no individual person can be identified.

4. On or before January first, two thousand twenty-six, the department shall create and maintain a public website called the "New York state Parkinson's disease registry" which shall include information on the incidence and prevalence of Parkinson's disease and Parkinsonisms in the state by county, and demographic information on affected patients.

§ 2013. Duties of the department. 1. Parkinson's disease reports and data shall be maintained by the department in a manner suitable for research purposes, and shall be made available to persons as set forth in section two thousand twelve of this article.

2. All information collected under this article shall be confidential insofar as the identity of individual patients is concerned and shall be used solely for the purposes as provided in this article. Access to such information shall be limited to authorized employees of the department as well as persons and organizations defined in section two thousand twelve of this article with valid scientific interest and qualifications, as determined by the commissioner, who are engaged in demographic, epidemiological, or other similar studies related to public health.

3. The department shall maintain an accurate record of all persons who are given access to the information contained in the Parkinson's disease registry. Such record shall include the name of the person authorizing access, the name, title and organizational affiliation of persons given access, dates of access, and the specific purposes for which information is to be used.

4. Any person who, in violation of a written agreement to maintain confidentiality, discloses any information provided under this section, or who uses information provided under this section in a manner other than that prescribed by the commissioner, may be denied further access to any confidential information maintained by the department.

§ 2014. Duties of the commissioner. The commissioner may promulgate any regulations necessary to implement the provisions of this article, including but not limited to:

1. Establishing the form, content, and manner by which providers shall report Parkinson's disease information into the registry established under section two thousand twelve of this article;

2. Prescribing the permissible uses for the information made available under this article; and

3. Establishing procedures to maintain the confidentiality of information collected by providers and provided to members of the department pursuant to this article. This shall include a procedure to ensure that confidential patient information is deidentified prior to being provided to authorized participants under this article.

* ARTICLE 20-C

**STATE FRONTOTEMPORAL DEGENERATION
REGISTRY**

Section 2015. Definitions.

2016. Duty to report.

2017. Establishment of registry.

2018. Duties of the department.

2019. Duties of the commissioner.

* NB There are 2 Art 20-C's

* **§ 2015. Definitions.** As used in this article, the following terms shall have the following meanings:

1. "Frontotemporal degeneration disorders" or "FTD disorders" means a group of clinical disorders caused by progressive nerve cell loss in the brain's frontal lobes and/or temporal lobes which can lead to loss of

function in these brain regions, which variably cause deterioration in behavior, personality and/or difficulty with producing or comprehending language, as well as loss of motor control and movement. For the purposes of this title frontotemporal degeneration disorders is the same as "FTD" and includes, but is not limited to behavioral variant FTD, primary progressive aphasia, corticobasal syndrome, and progressive supranuclear palsy. Some individuals with FTD may also be diagnosed with ALS.

2. "Dementia" means a usually progressive condition marked by the development of multiple cognitive deficits, which may include but is not exclusive to memory impairment, aphasia, and the inability to plan and initiate complex behavior. Dementia has numerous different causes including but not limited to FTD, Alzheimer's disease, Lewy Body Dementia and Vascular Dementia.

§ 2016. Duty to report. 1. Every physician, nurse practitioner, physician assistant and general hospital that diagnoses or is treating a patient diagnosed with FTD disorder shall give notice no later than one hundred eighty days of every case of FTD disorders coming under their care, to the department, in a format to be determined by the commissioner, except as otherwise provided in this article.

2. All patients diagnosed with FTD disorders shall be provided written and verbal notice regarding the collection of information and patient data on FTD disorders. Patients who do not wish to participate in the collection of data shall affirmatively opt-out in writing after ample opportunity to review such notice, provided that, the mere incidence of a patient with an FTD disorder shall be the sole required information for the registry under section two thousand seventeen of this article for any patient who chooses not to participate.

§ 2017. Establishment of registry. 1. The department shall establish a frontotemporal degeneration registry for the collection of information on the rate of clinical diagnoses of FTD disorders. The department shall

consult with FTD disorders experts, including neurologists, patients living with FTD disorders, and FTD disorders researchers to assist in the development and implementation of such registry, and to determine what data shall be collected.

2. All information maintained by the department under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

3. The department may enter into an agreement to provide data collected in the frontotemporal degeneration registry to the federal Centers for Disease Control and Prevention, or successor agency, to local health officers, or health researchers for the study of FTD disorders for public health and research purposes. Data shall be provided in summary, statistical, aggregate, or other form such that no individual person can be identified.

4. On or before January first, two thousand twenty-seven, the department shall create and maintain a public website called the "New York state frontotemporal degeneration registry" which shall include information on the rate of clinical diagnoses of FTD disorders in the state by county, and demographic information on affected patients.

§ 2018. Duties of the department. 1. FTD disorders reports and data shall be maintained by the department in a manner suitable for research purposes, and shall be made available to persons as set forth in section two thousand seventeen of this article.

2. All information collected under this article shall be confidential insofar as the identity of individual patients is concerned and shall be solely for the purposes as provided in this article. Access to such information shall be limited to authorized employees of the department as well as persons and organizations specified in section two thousand seventeen of this article with valid scientific interest and qualifications, as determined by the commissioner, who are engaged in

demographic, epidemiological, or other similar studies related to public health.

3. The department shall maintain an accurate record of all persons who are given access to the information contained in the frontotemporal degeneration registry. Such record shall include the name of the person authorizing access, the name, title and organizational affiliation of persons given access, dates of access, and the specific purposes for which information is to be used.

4. Any person who, in violation of a written agreement to maintain confidentiality, discloses any information provided under this section, or who uses information provided under this section in a manner other than that prescribed by the commissioner, may be denied further access to any confidential information maintained by the department.

§ 2019. Duties of the commissioner. The commissioner may promulgate any regulations necessary to implement the provisions of this article, including but not limited to:

1. establishing the form, content, and manner by which providers shall report FTD disorders information into the registry established under section two thousand seventeen of this article;

2. prescribing the permissible uses for the information made available under this article; and

3. establishing procedures to maintain the confidentiality of information collected by providers and provided to members of the department pursuant to this article. This shall include a procedure to ensure that confidential patient information is deidentified prior to being provided to authorized participants under this article.

* ARTICLE 20-C

STATE AMYOTROPHIC LATERAL SCLEROSIS AND MOTOR NEURON DISEASE

REGISTRY

Section 2020. Definitions.

2021. Duty to report.

2022. Establishment of registry.

2023. Duties of the department.

2024. Duties of the commissioner.

* NB There are 2 Art 20-C's

§ 2020. Definitions. As used in this article, the following terms shall have the following meanings:

1. "ALS" means amyotrophic lateral sclerosis, a neurological disorder that affects motor neurons, the nerve cells in the brain and spinal cord that control voluntary muscle movement and breathing.

2. "MND" means motor neuron disease, a group of progressive neurological disorders that destroy motor neurons, the cells that control skeletal muscle activity such as walking, breathing, speaking, and swallowing. This group includes diseases such as amyotrophic lateral sclerosis, progressive bulbar palsy, primary lateral sclerosis, progressive muscular atrophy, spinal muscular atrophy, Kennedy's disease, and post-polio syndrome.

§ 2021. Duty to report. 1. Every physician, nurse practitioner, physician assistant and general hospital that diagnoses or is treating a patient diagnosed with ALS or MND shall give notice no later than one hundred eighty days of each case of ALS or MND coming under their care, to the department, in a format to be determined by the commissioner, except as otherwise provided in this article.

2. All patients diagnosed with ALS or MND shall be provided with written and verbal notice regarding the collection of information and patient data on ALS and MND. Patients who do not wish to participate in the collection of data shall affirmatively opt out in writing after ample opportunity to review such notice, provided that the mere

incidence of a patient with ALS or MND shall be the sole required information for the registry under section two thousand twenty-two of this article for any patient who chooses not to participate.

§ 2022. Establishment of registry. 1. The department shall establish an ALS and MND registry for the collection of information on the incidence and prevalence of ALS and MND. The department may consult with ALS and MND experts, including neurologists, patients living with ALS and MND, and ALS and MND researchers to assist in the development and implementation of such registry, and to determine what data shall be collected.

2. All information maintained by the department under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

3. The department may enter into an agreement to provide data collected in the ALS and MND registry to the federal centers for disease control and prevention, or successor agency, to local health officers, or health researchers for the study of ALS and MND for public health and research purposes. Data shall be provided in summary, statistical, aggregate, or other form such that no individual person can be identified.

4. On or before January first, two thousand twenty-seven, the department shall create and maintain a public website called the "New York state ALS and MN Disease registry" which shall include information on the incidence and prevalence of ALS and MND in the state by county, and demographic information on affected patients.

§ 2023. Duties of the department. 1. ALS and MND reports and data shall be maintained by the department in a manner suitable for research purposes and shall be made available to people as set forth in section two thousand twenty-two of this article.

2. All information collection under this article shall be confidential insofar as the identity of individual patients is concerned and shall be used solely for the purposes as provided in this article. Access to such information shall be limited to authorized employees of the department as well as persons and organizations identified in section two thousand twenty-two of this article with valid scientific interest and qualifications, as determined by the commissioner, who are engaged in demographic, epidemiological, or other similar studies related to public health.

3. The department shall maintain an accurate record of all people who are given access to the information contained in the ALS and MND registry. Such a record shall include the name of the person authorizing access, the name, title and organizational affiliation of persons given access, dates of access, and the specific purposes for which information is to be used.

4. Any person who, in violation of a written agreement to maintain confidentiality, discloses any information provided under this article, or who uses information provided under this article in a manner other than that prescribed by the commissioner, may be denied further access to any confidential information maintained by the department.

§ 2024. Duties of the commissioner. The commissioner may promulgate any regulations necessary to implement the provisions of this article, including but not limited to:

1. Establishing the form, content, and manner by which providers shall report ALS and MND information into the registry established under section two thousand twenty-two of this article;

2. Prescribing the permissible uses for the information made available under this article; and

3. Establishing procedures to maintain confidentiality of information

collected by providers and provided to members of the department pursuant to this article. This shall include a procedure to ensure that confidential patient information is deidentified prior to being provided to authorized participants under this article.

ARTICLE 21

CONTROL OF ACUTE COMMUNICABLE DISEASES

- Title I. General provisions (§§ 2100-2112).
II. Control of patients (§§ 2120-2126).
III. Human Immunodeficiency Virus (§§ 2130-2139).
IV. Rabies (§§ 2140-2146).
V. Typhoid fever (§§ 2150-2153).
VI. Poliomyelitis and other diseases (§§ 2160-2169).
VII. Hepatitis C (§§ 2170-2171).
8. Novel coronavirus, COVID-19 (§§ 2180-2183).

TITLE I

GENERAL PROVISIONS

- Section 2100. Communicable diseases; local boards of health and health officers; powers and duties.
2101. Communicable diseases; physicians and institutions; duty to report.
2102. Communicable diseases; laboratory reports and records.
2103. Communicable diseases; local health officers; duty to report.
2104. Communicable diseases; municipalities within a county or part-county health district; duty to report.
2105. Communicable diseases; state institutions; duty to report; duty of commissioner.
2106. Communicable diseases; almshouses; removal of inmates.
2108. Communicable diseases; epidemic among Indians; state charges.
2109. Communicable diseases; municipal hospitals for; establishment, inspection and regulation.
2110. City of New York; exceptions.

2111. Disease management demonstration programs.

2112. Immunizations; prohibition on the use of mercury.

§ 2100. Communicable diseases; local boards of health and health officers; powers and duties. 1. Every local board of health and every health officer shall guard against the introduction of such communicable diseases as are designated in the sanitary code, by the exercise of proper and vigilant medical inspection and control of all persons and things infected with or exposed to such diseases.

2. Every local board of health and every health officer may:

(a) provide for care and isolation of cases of communicable disease in a hospital or elsewhere when necessary for protection of the public health and,

(b) subject to the provisions of the sanitary code, prohibit and prevent all intercourse and communication with or use of infected premises, places and things, and require, and if necessary, provide the means for the thorough purification and cleansing of the same before general intercourse with the same or use thereof shall be allowed.

§ 2101. Communicable diseases; physicians and institutions; duty to report. 1. Every physician shall immediately give notice of every case of communicable disease required by the department to be reported to it, to the health officer of the local health district where such disease occurs.

2. If there be no physician in attendance on any case of communicable disease, it shall be the duty of the superintendent or other officer of an institution, householder, hotel or lodging housekeeper, or other person where such case occurs, to give the notice of such case of communicable disease required by the department to be reported to it, to the health officer of the local health district where such disease occurs.

3. The sanitary code may provide that when cases of certain

communicable diseases occur (a) in districts of less than fifty thousand population not having a full-time health officer, or (b) in state institutions or (c) in tuberculosis hospitals or sanatoria, such cases shall be reported directly to the department or its district health officer.

4. Such notice shall contain such information concerning the case as shall be required by the sanitary code.

§ 2102. Communicable diseases; laboratory reports and records. 1. Whenever any laboratory examination discloses evidence of communicable disease, the results of such examination together with all required pertinent facts, shall be immediately reported by the person in charge of the laboratory or the person making such examination to the local or state health official to whom the attending physician is required to report such case.

2. The person in charge of such laboratory or the person making such examination shall keep for a period of time to be specified by the commissioner, a record of all the facts in connection with such examination, including the identity of the person from whom the specimen is taken and the name of the physician, if any, sending such specimen.

§ 2103. Communicable diseases; local health officers; duty to report. Every local health officer shall report promptly to the department, all cases of such communicable diseases as may be required by the department to be reported to it. In lieu of the original reports, the health officer may submit summary reports when authorized by the department.

§ 2104. Communicable diseases; municipalities within a county or part-county health district; duty to report. 1. The health officer of each city, village, town and consolidated health district included as part of any county or part-county health district, shall transmit daily all original reports of communicable disease cases to the county health

commissioner.

2. The county health commissioner shall transmit to the department the original reports of communicable disease cases within twenty-four hours after he receives them.

3. In lieu thereof, he may submit summary reports when authorized by the department.

§ 2105. Communicable diseases; state institutions; duty to report; duty of commissioner. 1. It shall be the duty of the director or person in charge of each state institution to report immediately an outbreak of a communicable disease in such institution to the commissioner and as may otherwise be provided in the sanitary code.

2. Upon receipt of a report from a state institution of the outbreak of a communicable disease in said institution, the commissioner shall advise the director or person in charge of the institution as to the best means to control said disease effectually.

§ 2106. Communicable diseases; almshouses; removal of inmates. If a communicable disease exists in any home operated by a public welfare district or in the vicinity thereof, and the physician thereof shall certify that such disease is likely to endanger the health of the inmates thereof, the public welfare commissioner of the district may cause such inmates or any of them to be removed to such other suitable place in the county as the local board of health of the health district where the almshouse is situated may designate, there to be maintained and provided for at the expense of the county, with all necessary medical care and attendance until they shall be safely returned to such home or otherwise discharged.

§ 2108. Communicable diseases; epidemic among Indians; state charges. 1. Whenever an epidemic of a communicable disease shall prevail among

the Indians of any nation, tribe or band in this state, the public welfare official of the welfare district in which the reservation of such nation, tribe or band, is wholly or partly situated, may in accordance with rules and regulations adopted by the commissioner, cause needed medical attendance, provisions and maintenance to be furnished to any indigent Indian residing in the town, who, or a member of whose family, is afflicted with such disease, while such disease shall continue. The cost thereof after being audited as herein provided shall be a state charge.

2. A verified statement of any expenses incurred under this section shall be transmitted by the public welfare official to the commissioner. The commissioner shall examine into the matter, and if satisfied that such expenses were properly and necessarily incurred in accordance with his rules and regulations, he shall approve the same; and the amount thereof, after audit by the comptroller, shall be paid from the state treasury on the warrant of the comptroller to such public welfare official.

§ 2109. Communicable diseases; municipal hospitals for; establishment, inspection and regulation. 1. The commissioner shall from time to time submit to the authorities of the several municipalities or counties of the state such recommendations as he may consider necessary as to the establishment of hospitals for communicable diseases, indicating the diseases for which in his judgment provision should be made and the extent of such provision.

2. It shall be the duty of the commissioner to inspect from time to time all hospitals for communicable diseases maintained under the jurisdiction of any municipal or county authority and to report as to the condition and needs of such hospitals to the authorities of the municipality or county, and to include an abstract of such reports in his annual report.

3. The public health council may from time to time establish regulations in the sanitary code for the maintenance of hospitals for

communicable diseases.

§ 2110. City of New York; exceptions. The provisions of sections two thousand one hundred to two thousand one hundred eight of this chapter, inclusive, shall not apply to the city of New York.

§ 2111. Disease management demonstration programs. 1. The department may establish disease management demonstration programs through a request for proposals process to enhance the quality and cost-effectiveness of care rendered to medicaid-eligible persons with chronic health problems whose care and treatment, because of one or more hospitalizations, multiple disabling conditions requiring residential treatment or other health care requirements, results in high medicaid expenditures. In order to be eligible to sponsor and to undertake a disease management demonstration program, the proposed sponsor may be a not-for-profit, for-profit or local government organization that has demonstrated expertise in the management or coordination of care to persons with chronic diseases or that has the experience of providing cost-effective community-based care to such patients, or in the case of a local government organization, has expressed a strong willingness to sponsor such a program. The department may also approve disease management demonstration programs which include, but are not limited to, the promotion of adherence to evidence-based guidelines, improvement of provider and patient communication and provide information on provider and beneficiary utilization of services. The department shall grant no fewer than six demonstration programs, no more than one-third of such programs shall be selected to provide these services in any single social services district; provided further, where the department grants less than six demonstration programs, no more than one such program shall be selected to provide these services in any single social services district. The department shall approve disease management demonstration programs which are geographically diverse and representative of both urban and rural social services districts. The program sponsor must establish, to the satisfaction of the department, its capacity to enroll and serve sufficient numbers of enrollees to

demonstrate the cost-effectiveness of the demonstration program.

2. The department shall establish the criteria by which individuals will be identified as eligible for enrollment in the demonstration programs. Persons eligible for enrollment in the disease management demonstration program shall be limited to individuals who: receive medical assistance pursuant to title eleven of article five of the social services law and may be eligible for benefits pursuant to title 18 of the social security act (Medicare); are not enrolled in a Medicaid managed care plan, including individuals who are not required or not eligible to participate in Medicaid managed care programs pursuant to section three hundred sixty-four-j of the social services law; are diagnosed with chronic health problems as may be specified by the entity undertaking the demonstration program, including, but not limited to one or more of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, diabetes or other chronic health conditions as may be specified by the department; or have experienced or are likely to experience one or more hospitalizations or are otherwise expected to incur excessive costs and high utilization of health care services.

3. Enrollment in a demonstration program shall be voluntary. A participating individual may discontinue his or her enrollment at any time without cause. The commissioner shall review and approve all enrollment and marketing materials for a demonstration program.

4. The demonstration program shall offer evidence-based services and interventions designed to ensure that the enrollees receive high quality, preventative and cost-effective care, aimed at reducing the necessity for hospitalization or emergency room care or at reducing lengths of stay when hospitalization is necessary. The demonstration program may include screening of eligible enrollees, developing an individualized care management plan for each enrollee and implementing that plan. Disease management demonstration programs that utilize information technology systems that allow for continuous application of evidence-based guidelines to medical assistance claims data and other available data to identify specific instances in which clinical interventions are justified and communicate indicated interventions to

physicians, health care providers and/or patients, and monitor physician and health care provider response to such interventions, shall have the enrollees, or groups of enrollees, approved by the department for participation. The services provided by the demonstration program as part of the care management plan may include, but are not limited to, case management, social work, individualized health counselors, multi-behavioral goals plans, claims data management, health and self-care education, drug therapy management and oversight, personal emergency response systems and other monitoring technologies, telehealth services and similar services designed to improve the quality and cost-effectiveness of health care services.

5. The department shall be responsible for monitoring the quality, appropriateness and cost-effectiveness of a demonstration program. The department shall utilize, to the extent possible, all potential sources of funding for demonstration programs, including, but not limited to, private payments and donations. All such funds shall be deposited by the commissioner and credited to the disease management account which shall be established by the comptroller in the special revenue-other fund. Additionally, to the extent of funds appropriated therefor, medical assistance funds, including any funding or shared savings as may become available through federal waivers or otherwise under titles 18 and 19 of the federal social security act, may be used by the department for expenditures in support of the disease management program.

6. Payments shall be made by the department to the entity responsible for the operation of the demonstration program on a fixed amount per member per month of enrollment and shall reimburse the program sponsor for the services rendered pursuant to subdivision four of this section. The amount paid shall be an amount reasonably necessary to meet the costs of providing such services, provided that the total amount paid for medical assistance to enrollees in any such disease management demonstration program, including any demonstration program expenditures, shall not exceed ninety-five percent of the medical assistance expenditure related to such enrollee that would reasonably have been anticipated if the enrollee had not been enrolled in such demonstration program. The department may make payments to demonstration programs that

provide administrative services only, provided that expenditures made for enrollees, or a group of enrollees, participating in the demonstration program shall provide sufficient savings as determined by the department, had the enrollees, or groups of enrollees, not been enrolled in such demonstration. The department shall provide an interim report to the governor, and the legislature on or before December thirty-first, two thousand six and a final report on or before December thirty-first, two thousand seven on the results of demonstration programs. Both reports shall include findings as to the demonstration programs' contribution to improving quality of care and their cost-effectiveness. In the final report, the department shall offer recommendations as to whether demonstration programs should be extended, modified, eliminated or made permanent.

§ 2112. Immunizations; prohibition on the use of mercury. 1. Except as otherwise provided in subdivisions two, three, four and five of this section, no person under three years of age and no woman who knows she is pregnant shall be vaccinated with a vaccine that contains more than 0.5 micrograms of mercury per 0.5 milliliter dose.

2. Persons under three years of age may be vaccinated with an influenza vaccine that contains not more than 0.625 micrograms of mercury per 0.25 milliliter dose.

3. Women who know they are pregnant may be vaccinated with an influenza vaccine that contains not more than 1.25 micrograms of mercury per 0.50 milliliter dose; provided, however, that no provision of this section shall apply to the administration of influenza vaccine to women who know they are pregnant until and unless the commissioner makes a yearly determination that there is an adequate supply of influenza vaccine that contains not more than 1.25 micrograms of mercury per 0.50 milliliter dose to meet anticipated demand.

4. The commissioner may authorize the use of vaccines containing more than the mercury levels described in subdivisions one, two and three of this section when he or she determines it is necessary to prevent or

respond to an outbreak of disease and there are insufficient amounts of vaccine containing the mercury levels described in subdivision one, two or three of this section to adequately protect the public health. Such authorization shall continue until the commissioner determines that the threat of an outbreak or the outbreak has ended.

5. The commissioner may authorize the use of specific vaccines containing more than the mercury levels described in subdivisions one, two and three of this section when he or she determines that a vaccine with lower mercury levels is not available for distribution in this state, and the parent of a person under three years of age provides informed consent to administration of such vaccine to his or her child or the woman who knows she is pregnant provides informed consent to the administration of such vaccine.

TITLE II

CONTROL OF PATIENTS

Section 2120. Communicable diseases; control of dangerous and careless patients; commitment.

2121. Communicable diseases; duty of committed patients; discipline.

2122. Communicable diseases; disorderly committed patients; commitment to penal institution.

2123. Communicable diseases; discharge of committed patient; duty to report.

2124. Communicable diseases; appeal by committed patient.

2125. City of New York; exceptions.

§ 2120. Communicable diseases; control of dangerous and careless patients; commitment. 1. Whenever a complaint is made by a physician to a health officer that any person is afflicted with a communicable disease or is a carrier of typhoid fever, tuberculosis, diphtheria or other communicable disease and is unable or unwilling to conduct himself and to live in such a manner as not to expose members of his family or household or other persons with whom he may be associated to danger of

infection, the health officer shall forthwith investigate the circumstances alleged.

2. If the health officer finds after investigation that a person so afflicted is a menace to others, he shall make and file a complaint against such person with a magistrate, and on such complaint the said person shall be brought before such magistrate.

3. The magistrate after due notice and a hearing, if satisfied that the complaint of the health officer is well founded and that the afflicted person is a source of danger to others, may commit the said person to any hospital or institution established for the care of persons suffering from any such communicable disease or maintaining a room, ward or wards for such persons.

4. In making such commitment the magistrate shall make such order for payment for the care and maintenance of the person committed as he may deem proper.

5. A person who is committed pursuant to the provisions of this section shall be deemed to be committed until discharged in the manner authorized by section two thousand one hundred twenty-three of this chapter.

§ 2121. Communicable diseases; duty of committed patients; discipline.

1. Every person committed under the provisions of this article shall observe all the rules and regulations of the hospital or institution to which he is committed.

2. Any person so committed who neglects or refuses to obey the rules and regulations of the institution may by direction of the chief medical officer of the institution be placed apart from the other patients.

§ 2122. Communicable diseases; disorderly committed patients; commitment to penal institution. 1. Any person who has been committed to

a hospital or institution pursuant to the provisions of section two thousand one hundred twenty of this chapter, who thereafter wilfully violates the rules and regulations of the institution or repeatedly conducts himself in a disorderly manner may be taken before a magistrate by the order of the chief medical officer of the institution.

2. The chief medical officer of the institution may enter a complaint against such person for disorderly conduct and the magistrate, after a hearing and upon sufficient evidence of such disorderly conduct, may commit such person for a period not to exceed six months to any institution to which persons convicted of disorderly conduct, vagrancy or similar violations are committed.

3. The authorities of the institution to which such person is committed by the magistrate pursuant to the provisions of this section shall keep such person separate and apart from the other incarcerated individuals.

§ 2123. Communicable diseases; discharge of committed patient; duty to report. 1. The chief medical officer of the hospital or other institution to which any person who has been committed pursuant to the provisions of section two thousand one hundred twenty of this chapter upon signing and placing among the permanent records of such hospital or institution a statement to the effect that such person has obeyed the rules and regulations of such hospital or institution, and that in his judgment such person may be discharged without danger to the health or life of others, or for any other reason stated in full which he may deem adequate and sufficient, may discharge the person so committed.

2. The chief medical officer shall report each such discharge together with a full statement of the reasons therefor at once to the health officer of the local health district from which the patient came and at the next meeting of the board of managers or other controlling authority of such hospital or institution.

§ 2124. Communicable diseases; appeal by committed patient. Nothing contained in this article shall be construed to prohibit any person committed to any institution pursuant to its provisions from appealing to any court having jurisdiction, for a review of the evidence on which commitment was made.

§ 2125. City of New York; exceptions. The provisions of sections two thousand one hundred twenty to two thousand one hundred twenty-four of this chapter, inclusive, shall not apply to the city of New York.

TITLE III

HUMAN IMMUNODEFICIENCY VIRUS

- Section 2130. AIDS and HIV infection; duty to report.
- 2131. Municipal health commissioner; duty to report.
 - 2132. Reporting of HIV infection after death.
 - 2133. Contact tracing of cases of AIDS, HIV related illness or HIV infection.
 - 2134. Disclosure of medical information.
 - 2135. Confidentiality.
 - 2136. Liability.
 - 2137. Domestic violence recognition.
 - 2138. Anonymous testing.
 - 2139. Rules and regulations.

§ 2130. AIDS and HIV infection; duty to report. 1. Every physician or other person authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests shall immediately (a) upon determination that a person is infected with human immunodeficiency virus (HIV), (b) upon diagnosis that a person is afflicted with the disease known as acquired immune deficiency syndrome (AIDS), (c) upon diagnosis that a person is afflicted with HIV related illness, and (d) upon periodic monitoring of HIV infection by any laboratory tests report such case or data to the commissioner.

2. The commissioner shall promptly forward such report to the health commissioner of the municipality where such disease, illness or infection occurred. When cases of such disease, illness or infection occur in a municipality not having a health commissioner, such reports shall be forwarded directly to the district health officer.

3. Such report shall contain such information concerning the case as shall be required by the commissioner. Such report shall include information identifying the protected individual as well as the names, if available, of any contacts of the protected individual, as defined in subdivision ten of section twenty-seven hundred eighty of this chapter, known to the physician or provided to the physician by the infected person.

§ 2131. Municipal health commissioner; duty to report. If any contact resides in a county or district other than the one where the protected individual is found, the health officer receiving the report shall refer the contact report to the health officer in the county or district where the contact resides, who shall then make a good faith effort to notify such contact and otherwise comply with the provisions of section twenty-one hundred thirty-three of this title.

§ 2132. Reporting of HIV infection after death. If a coroner, pathologist, medical examiner, or other person qualified to conduct an examination of a deceased person discovers that at the time of death the individual was afflicted with AIDS, HIV related illness or HIV infection, he or she shall report the case promptly to the commissioner according to the manner provided in this title as if the diagnosis had been established prior to death.

§ 2133. Contact tracing of cases of AIDS, HIV related illness or HIV infection. 1. Every municipal health commissioner or the department's district health officer, upon determination that such reported case or, any other known case of HIV infection merits contact tracing in order to

protect the public health, shall personally or through their qualified representatives notify the known contacts of the protected individual. Such contact tracing shall be done consistent with protocols developed pursuant to section twenty-one hundred thirty-seven of this title.

2. Such contact shall also be informed of (a) the nature of HIV, (b) the known routes of transmission of the virus, (c) as circumstances may require, the risks of prenatal and perinatal transmission, (d) actions he or she can take to limit further transmission of the virus, (e) other facilities or community based organizations which are accessible to the person that provide counseling, medical care and treatment, further information or other appropriate services for persons infected with HIV.

3. In notifying any contact identified in the course of any investigation conducted pursuant to this section, the physician or public health officer shall not disclose the identity of the protected individual or the identify of any other contact.

4. A physician or public health officer making a notification to a contact pursuant to this section shall make such notification in person except where circumstances reasonably prevent doing so.

§ 2134. Disclosure of medical information. Disclosure of medical information obtained in accordance with this title, including a diagnosis of HIV infection, may be made only to (a) the protected individual, (b) the municipal health commissioner or district health officer if such commissioner or officer is not the examining physician, and (c) without specifically revealing the identity of the protected individual, contacts as defined pursuant to subdivision ten of section twenty-seven hundred eighty of this chapter.

§ 2135. Confidentiality. All reports or information secured by the department, municipal health commissioner or district health officer under the provisions of this title shall be confidential except: (a) in so far as is necessary to carry out the provisions of this title; (b)

when used in the aggregate, without patient specific identifying information, in programs approved by the commissioner for the improvement of the quality of medical care provided to persons with HIV/AIDS; (c) when used within the state or local health department by public health disease programs to assess co-morbidity or completeness of reporting and to direct program needs, in which case patient specific identifying information shall not be disclosed outside the state or local health department; or (d) when used for purposes of patient linkage and retention in care, patient specific identified information may be shared between local and state health departments and health care providers currently treating the patient as approved by the commissioner.

§ 2136. Liability. 1. Good faith reporting or disclosure pursuant to this title shall not constitute libel or slander or a violation of the right of privacy or privileged communication.

2. Any person who in good faith complies with this title shall be immune from civil and criminal liability for any action taken in compliance with its provisions.

3. No criminal or civil liability shall arise against any protected individual solely due to his or her failure to cooperate in contact tracing conducted pursuant to section twenty-one hundred thirty-three of this title.

§ 2137. Domestic violence recognition. The department shall, in consultation with the office for the prevention of domestic violence and statewide organizations and community based organizations, develop a protocol for the identification and screening of victims of domestic violence who may either be a protected individual or a contact as used in this title.

§ 2138. Anonymous testing. Nothing in this article shall be

interpreted to eliminate the anonymous testing option provided for in section twenty seven hundred eighty-one of this chapter.

§ 2139. Rules and regulations. The commissioner shall promulgate such rules and regulations as shall be necessary and proper to effectuate the purposes of this title.

TITLE IV RABIES

Section 2140. Definitions.

- 2141. Compulsory vaccination.
- 2142. Rabies; emergency provisions.
- 2143. Rabies; seizure and disposal; reports.
- 2144. Rabies; county responsibility.
- 2145. Rabies; services and expenses of suppression.
- 2146. City of New York; exceptions.

§ 2140. Definitions. For the purpose of this title:

1. "Actively immunized" shall mean that the animal has been injected with a rabies vaccine suitable to the species and which meets the standards prescribed by the United States department of agriculture for interstate sale and which was administered according to the manufacturer's instructions under the direction of a duly licensed veterinarian not later than the expiration date on the package. Active immunization shall begin fourteen days following primary vaccination or immediately following a booster vaccination, and continue for the period stated in the manufacturer's instructions.

2. "County" shall mean a county of the state other than those in the city of New York.

3. "County health authority" shall mean the county health agency.

4. "Domestic livestock" includes cattle, goats, horses, donkeys, mules, sheep, and swine.

5. "Certificate of immunization" shall mean a signed statement issued by the veterinarian containing the following information: name and address of the owner, date or dates of vaccination, type of vaccine administered and duration of immunity, amount and manner of administration, name of manufacturer of the vaccine, and the lot number and expiration date of the vaccine. The certificate of immunization for domestic livestock may include multiple animals. The system of identification applicable to the livestock is to be used.

6. "Owner" shall mean any person keeping, harboring, or having charge or control of, or permitting any dog, cat or domesticated ferret to remain on or be lodged or fed within such person's house, yard, or premises. This term shall not apply to veterinarians or other facilities temporarily maintaining on their premises dogs, cats or domesticated ferrets owned by others for periods of no more than four months or to the owner or occupant of property inhabited by a feral animal.

7. "Confinement and observation" refers to the conditions under which apparently healthy dogs, cats, domesticated ferrets, and domestic livestock, which are not exhibiting symptoms of rabies, must be maintained to determine rabies status if such an animal has potentially exposed a person to rabies, and the owner wishes to avoid euthanizing and testing the animal. If the county health authority does not approve home confinement, the ten day confinement and observation period must take place, at owner's expense, at an appropriate facility such as an animal shelter, veterinarian's office, kennel or farm. The confinement must include (i) provisions to prevent escape of the animal during the confinement period and (ii) requirements that the owner notify the public health authority immediately if the animal becomes ill at anytime during confinement, and (iii) verification by the county health authority or their designee at the end of the ten day period that the animal is healthy. If a police work dog bites an individual in the course of such dog's official duty the police department may apply for a

waiver from confinement from the local department of health. As part of such application for a waiver, the police department shall provide the local health department with records of such dog's past vaccination for rabies and proof that such dog's rabies vaccinations are up-to-date.

8. "Quarantine" refers to a six month period of restriction for animals which are not actively immunized against rabies and have been exposed to a potentially rabid animal, in accordance with applicable regulations of the department. The quarantine must include provisions to prevent escape of the animal during the quarantine period and to minimize contacts with humans and other animals, and these provisions must be verified by the county health authority during and at the end of the six month period.

9. "Local residence", under the conditions hereinafter specified, shall mean any person who has his or her primary residence, secondary residence, vacation home or school within a county of the state of New York shall be deemed to have local residence in such county.

10. "Qualification on residence." Local residence shall not include residence:

- (a) as an incarcerated individual of any state or federal prison, or
- (b) on a military reservation.

11. "Initial treatment after human exposure to rabies" shall mean administration of the first postexposure dose of rabies vaccine and, when necessary, administration of rabies immune globulin.

12. "Animal control officer" shall mean one or more persons designated by the county health authority as having responsibility for animal control issues in the county. This responsibility may be delegated to others such as cities and towns, law enforcement agencies, animal shelters, or private nuisance control officers.

13. "Feral animal" shall mean any cat, dog or ferret that is born in the wild and is not socialized, is the offspring of an owned or feral cat, dog or ferret and is not socialized, or is a formerly owned cat,

dog or ferret that has been abandoned and is no longer socialized.

§ 2141. Compulsory vaccination. 1. Every dog, cat and domesticated ferret shall be actively immunized against rabies in accordance with regulations promulgated by the commissioner. Every dog, cat and domesticated ferret shall have all initial vaccinations administered no later than four months after birth. Every dog, cat and domesticated ferret shall have a second vaccination within one year of the first. Terms of subsequent vaccine administration and duration of immunity must be in compliance with USDA licenses of vaccines used. The veterinarian immunizing or supervising any person authorized by law to immunize such animal shall provide the owner with a certificate of immunization consistent with the requirements of section one hundred nine of the agriculture and markets law. The veterinarian immunizing or supervising any person authorized by law to immunize such animal shall provide any public health official with the certificate of immunization in any case involving a dog, cat or domesticated ferret which has been or may have been exposed to rabies or in any case of possible exposure of a person or another animal to rabies.

2. Subdivision one of this section shall not apply to any feral animal or any dog, cat or domesticated ferret:

(a) that is transported through the state and remains in the state fifteen days or fewer;

(b) confined to the premises of an incorporated society devoted to the care of lost, stray or homeless animals;

(c) for which vaccination against rabies would adversely affect the animal's health, as determined by a licensed veterinarian; or

(d) confined for the purposes of research to the premises of a college or other educational or research institution.

3. (a) Every veterinarian providing treatment to a dog, cat or domesticated ferret shall verify, in accordance with standards established by the commissioner, if such animal is actively immunized against rabies or is exempt under subdivision two of this section. If active immunization or exemption cannot be verified, the veterinarian

shall immunize the animal at the owner's request.

(b) If the animal is exempt from the provisions of subdivision one of this section, pursuant to paragraph (c) of subdivision two of this section, the veterinarian shall provide the owner of the dog, cat or domesticated ferret with a certified statement verifying that the animal is exempt from immunization because the immunization would adversely affect the health of the animal, and verifying the nature and duration of such exemption. The certified statement shall be in a form prescribed by the commissioner and shall be consistent with the requirements of section one hundred nine of the agriculture and markets law. Medical exemptions are to be renewed on an annual basis.

4. The owning of a dog, cat or domesticated ferret by any person in violation of subdivision one of this section shall constitute a violation, and shall be subject to a fine not to exceed two hundred dollars for each offense.

§ 2142. Rabies; emergency provisions. Whenever the commissioner confirms an outbreak of the disease rabies in terrestrial animals in any county or the vicinity thereof, the commissioner shall declare a rabies alert for that area and so certify to the county or local health authorities or any local health district contained therein. It shall be the duty of the health officials to immediately and annually thereafter publish a notice of the existence of the disease, together with a summary of the provisions of this title, in a newspaper generally circulated within the county or local health district, or to post notices in several conspicuous places, or both. Such certification shall remain in force until such time as the commissioner confirms that the outbreak is over.

§ 2143. Rabies; seizure and disposal; reports. Whenever the commissioner certifies a county to have a rabies alert pursuant to section twenty-one hundred forty-two of this title, any duly appointed dog control officer, animal control officer, peace officer, police officer, or health officer for that area may seize and confine any dog,

cat or domesticated ferret found at large and may destroy a dog, cat or domesticated ferret found at large that is exhibiting symptoms of rabies and cannot be seized without placing any person at serious risk of physical injury. Any duly appointed person who seizes, confines, or destroys a dog, cat or domesticated ferret pursuant to this section shall immediately report in writing the facts relating thereto to the county or local health authority.

§ 2144. Rabies; county responsibility. Each county health authority is required to develop a rabies control protocol that identifies and coordinates all activities within the county to accomplish a comprehensive rabies response. The county health authority shall have responsibility for the implementation of the protocol, including the coordination of the response to rabies issues by other local agencies. This protocol must be approved by the department and revised and updated as directed by the department.

§ 2145. Rabies; services and expenses of suppression. 1. The county health authority is responsible for the services and expenses necessary for the suppression of human rabies. Suppression of human rabies shall include, but not be limited to:

(a) availability at all times for prompt investigation of reports of possible exposures to rabies of people, pets, or domestic livestock occurring within the county, and to render authorization for human postexposure treatment,

(b) making arrangements for appropriate disposition of the animals involved, including confinement and observation, quarantines, vaccination boosters, or euthanasia and testing,

(c) collection, preparation and submission of animal specimens to a laboratory approved by the commissioner for rabies diagnosis,

(d) verifying terms of confinement, observation and quarantines,

(e) authorized human postexposure treatment under the conditions hereinafter specified, except that third party coverage or indemnification shall first be applied against the cost of treatment, and

(f) operation of rabies vaccination clinics free of charge for dogs, cats and domesticated ferrets owned by persons with local residence.

2. Under the conditions specified below, the county health authority is responsible for authorized human postexposure treatment for all persons exposed within the county, regardless of the location of the person's residence; except in any case where the person's county of residence has agreed to be responsible for such treatment in accordance with the provisions of this title. In addition, for persons with local residence who are exposed to rabies in New York city or out of state, the county health authority is responsible for that portion of treatment that occurs after such persons return to their local residences.

3. Human postexposure treatment specifically authorized by the county health authority shall be rendered by the provider or providers selected by the county health authority, located within the county or the vicinity thereof, and shall be considered sufficient authorization for pre-approval by the person's health insurance carrier or managed care plan if pre-approval is required, and shall be approved, by the health insurance carrier or managed care plan, provided that:

(a) any person may, at his or her option, be treated at his or her own expense by the health care provider of his or her choice without approval by the county health authority,

(b) the county health authority may, at its option, assume financial responsibility for necessary treatment rendered by other providers; provided, however, that the county health authority shall not be obligated to assume financial responsibility if notified after the completion of treatment. If evidence of approval of the county health authority has not been provided, health care providers must report initiation of rabies postexposure prophylaxis within twenty-four hours of the first treatment,

(c) the county shall authorize initial treatment from a provider or providers geographically accessible to the location of the exposed person at the time that treatment is determined to be necessary, and

(d) the county shall authorize post-initial treatment from a provider or providers geographically accessible to the exposed person's residence if the person returns to his or her residence during the course of

treatment.

4. Consent by any person to human postexposure treatment authorized by the county health authority shall constitute assignment of any third party health benefits to the county health authority and permission for the person's health care and insurance providers to release medical and financial information regarding the treatment to the county health authority.

5. Health care and insurance providers shall comply with any requests by the county health authority for information regarding human postexposure treatment rendered to an enrollee whose treatment was authorized by the county health authority.

5-a. Health care providers shall accept payments by the county health authority for human postexposure treatment at a rate set by the commissioner; provided that such reimbursement shall be no less than the Medicaid rate.

6. Under the terms of this title, the county health authority is not responsible for:

(a) services and expenses of human postexposure treatment that were not specifically authorized by the county health authority, except for completion of treatment for their residents exposed and started on rabies treatment in New York city or elsewhere outside of New York state. Treatment started in New York city shall be confirmed as necessary treatment by the New York city department of health and mental hygiene, or the department,

(b) services and expenses of medical treatment unrelated to the prevention of rabies infection such as wound suturing and measures to control bacterial infection of bite wounds, and

(c) expenses of preexposure rabies vaccination.

7. A clinic for rabies vaccination for dogs, cats and domesticated ferrets of persons with local residence shall be conducted at least every four months within the county under the direction of the county government, by the health officials of the county and the several local

health districts within a county. Donations may be requested but not required at the clinics. Any listing of costs in clinic announcements or advertisements must indicate that vaccinations are available free of charge, and that donations are optional. Counties may at their option provide vaccination clinic services to persons without county residence, and may require a fee based on cost from these persons.

8. Claims for services and expenses, approved by the county shall be paid by the fiscal officer of the county from funds in his or her custody upon presentation of such claim, without further or other audit or may be paid pursuant to the local finance law.

§ 2146. City of New York; exceptions. The provisions of sections two thousand one hundred forty through two thousand one hundred forty-five of this title, inclusive, shall not apply to the city of New York.

TITLE V

TYPHOID FEVER

Section 2150. Typhoid fever; carriers; care and maintenance, in institutions.

2151. Typhoid fever; carriers; care and maintenance, privately.

2152. Typhoid fever; carriers; care and maintenance, payment of expenses.

2153. City of New York; exceptions.

§ 2150. Typhoid fever; carriers; care and maintenance, in institutions. Whenever any person is declared by the commissioner to be a carrier of typhoid fever bacilli and whenever, for the protection of the public health, the commissioner certifies to the necessity of continued isolation; or, whenever, the sanitary code prohibits a carrier of typhoid fever bacilli from engaging in his usual occupation, such person may be given hospital or institutional care under the surveillance of the local health officer at the expense of the state if the hospital or institution in the judgment of the commissioner is

properly equipped for the care and maintenance of said person.

§ 2151. Typhoid fever; carriers; care and maintenance, privately.

When no hospital or institution is available for the care of a carrier of typhoid fever bacilli in accordance with the provisions of section two thousand one hundred fifty of this chapter, and when in the opinion of the commissioner such person may be cared for at home or in a private family with due regard to the protection of the public health, the commissioner may furnish necessary medical attendance and maintenance and designate the agency or person through which such medical attendance and maintenance shall be furnished.

§ 2152. Typhoid fever; carriers; care and maintenance, payment of expenses. 1. No expenditure for the purposes authorized in sections two thousand one hundred fifty and two thousand one hundred fifty-one of this chapter, shall be contracted for or incurred by any agency or person until after such expense has been authorized and approved by the commissioner.

2. (a) A verified statement of any such approved expense incurred pursuant to this section and sections two thousand one hundred fifty and two thousand one hundred fifty-one of this chapter, shall be transmitted to the commissioner.

(b) The commissioner shall examine the statement and if satisfied that such authorized expenses are correct and necessary in accordance with rules and regulations adopted by him he shall audit and allow the same and when so audited the amount thereof shall be paid by the state department of taxation and finance, on the warrant of the state comptroller to the institution, agency or person.

§ 2153. City of New York; exceptions. The provisions of sections two thousand one hundred fifty to two thousand one hundred fifty-two of this chapter, inclusive, shall not apply to the city of New York.

TITLE VI

POLIOMYELITIS AND OTHER DISEASES

- Section 2160. Poliomyelitis; persons twenty-one years of age and over; medical inspection.
2161. Poliomyelitis; persons twenty-one years of age and over; care and maintenance.
2162. Poliomyelitis; application of statute; city of New York.
2164. Definitions; immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenzae type b (Hib), pertussis, tetanus, pneumococcal disease, meningococcal disease, and hepatitis B.
2165. Immunization of certain post-secondary students.
2166. Immunization; regulations.
2167. Immunization against meningococcal meningitis.
2168. Statewide immunization information system.
2169. Vaccine confidentiality.

§ 2160. Poliomyelitis; persons twenty-one years of age and over; medical inspection. In addition to the powers and duties prescribed by section two thousand one hundred of this chapter, every local board of health and every health officer shall exercise proper and vigilant medical inspection of all persons twenty-one years of age or over, infected or who have been infected with poliomyelitis.

§ 2161. Poliomyelitis; persons twenty-one years of age and over; care and maintenance. Every county or part-county health commissioner, city health officer in cities having more than fifty thousand population, and state district health officer shall, within their respective areas and after approval by the commissioner, provide at the remediable stages of the disease known as poliomyelitis, suitable surgical, medical or therapeutic treatment or hospital care, and necessary appliances and devices for all persons twenty-one years of age or over including Indians residing on reservations, so infected or exposed who cannot

otherwise be provided for. In a county the determination as to what persons cannot otherwise be provided for and relevant matters shall be made by the board of supervisors of such county against which the same is to be a charge and an investigation and report thereon to such board upon which to make its determination shall be made by the public welfare commissioner or such other county officer, or committee of the board as the board of supervisors may designate by resolution. The charges approved for such treatment shall be in full payment thereof and shall be accepted by the person or corporation furnishing such treatment as full payment and no such person or corporation shall ask or receive directly or indirectly any other or additional compensation.

§ 2162. Poliomyelitis; application of statute; city of New York.

Notwithstanding any other provision of this chapter or any other general, special or local law, the terms "local board of health" and "health officers" as used in sections two thousand one hundred sixty and two thousand one hundred sixty-one of this chapter shall include the department of health of the city of New York.

§ 2164. Definitions; immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenzae type b (Hib), pertussis, tetanus, pneumococcal disease, meningococcal disease, and hepatitis B. 1. As used in this section, unless the context requires otherwise:

a. The term "school" means and includes any public, private or parochial child caring center, day nursery, day care agency, nursery school, kindergarten, elementary, intermediate or secondary school.

b. The term "child" shall mean and include any person between the ages of two months and eighteen years.

c. The term "person in parental relation to a child" shall mean and include his father or mother, by birth or adoption, his legally appointed guardian, or his custodian. A person shall be regarded as the

custodian of a child if he has assumed the charge and care of the child because the parents or legally appointed guardian of the minor have died, are imprisoned, are mentally ill, or have been committed to an institution, or because they have abandoned or deserted such child or are living outside the state or their whereabouts are unknown, or have designated the person pursuant to title fifteen-A of article five of the general obligations law as a person in parental relation to the child.

d. The term "health practitioner" shall mean any person authorized by law to administer an immunization.

2. a. Every person in parental relation to a child in this state shall have administered to such child an adequate dose or doses of an immunizing agent against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, Haemophilus influenzae type b (Hib), pertussis, tetanus, pneumococcal disease, and hepatitis B, in accordance with regulations issued by the commissioner, utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the Advisory Committee on Immunization Practices, and/or other similar nationally or internationally recognized scientific organizations.

b. Every person in parental relation to a child in this state born on or after January first, nineteen hundred ninety-four and entering sixth grade or a comparable age level special education program with an unassigned grade on or after September first, two thousand seven, shall have administered to such child a booster immunization containing diphtheria and tetanus toxoids, and an acellular pertussis vaccine, in accordance with regulations issued by the commissioner, utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the Advisory Committee on Immunization Practices, and/or other similar nationally or internationally recognized scientific organizations.

c. Every person in parental relation to a child in this state entering or having entered seventh grade and twelfth grade or a comparable age level special education program with an unassigned grade on or after September first, two thousand sixteen, shall have administered to such child an adequate dose or doses of immunizing agents against meningococcal disease in accordance with regulations issued by the commissioner, utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the Advisory Committee on Immunization Practices, and/or other similar nationally or internationally recognized scientific organizations.

3. The person in parental relation to any such child who has not previously received such immunization shall present the child to a health practitioner and request such health practitioner to administer the necessary immunization against poliomyelitis, mumps, measles, diphtheria, Haemophilus influenzae type b (Hib), rubella, varicella, pertussis, tetanus, pneumococcal disease, meningococcal disease, and hepatitis B as provided in subdivision two of this section.

4. If any person in parental relation to such child is unable to pay for the services of a private health practitioner, such person shall present such child to the health officer of the county in which the child resides, who shall then administer the immunizing agent without charge.

5. The health practitioner who administers such immunizing agent against poliomyelitis, mumps, measles, diphtheria, Haemophilus influenzae type b (Hib), rubella, varicella, pertussis, tetanus, pneumococcal disease, meningococcal disease, and hepatitis B to any such child shall give a certificate of such immunization to the person in parental relation to such child.

6. In the event that a person in parental relation to a child makes

application for admission of such child to a school or has a child attending school and there exists no certificate or other acceptable evidence of the child's immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, hepatitis B, pertussis, tetanus, and, where applicable, Haemophilus influenzae type b (Hib), meningococcal disease, and pneumococcal disease, the principal, teacher, owner or person in charge of the school shall inform such person of the necessity to have the child immunized, that such immunization may be administered by any health practitioner, or that the child may be immunized without charge by the health officer in the county where the child resides, if such person executes a consent therefor. In the event that such person does not wish to select a health practitioner to administer the immunization, he or she shall be provided with a form which shall give notice that as a prerequisite to processing the application for admission to, or for continued attendance at, the school such person shall state a valid reason for withholding consent or consent shall be given for immunization to be administered by a health officer in the public employ, or by a school physician or nurse. The form shall provide for the execution of a consent by such person and it shall also state that such person need not execute such consent if subdivision eight of this section applies to such child.

7. (a) No principal, teacher, owner or person in charge of a school shall permit any child to be admitted to such school, or to attend such school, in excess of fourteen days, without the certificate provided for in subdivision five of this section or some other acceptable evidence of the child's immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, hepatitis B, pertussis, tetanus, and, where applicable, Haemophilus influenzae type b (Hib), meningococcal disease, and pneumococcal disease; provided, however, such fourteen day period may be extended to not more than thirty days for an individual student by the appropriate principal, teacher, owner or other person in charge where such student is transferring from out-of-state or from another country and can show a good faith effort to get the necessary certification or other evidence of immunization.

(b) A parent, a guardian or any other person in parental relationship to a child denied school entrance or attendance may appeal by petition

to the commissioner of education in accordance with the provisions of section three hundred ten of the education law.

8. If any physician licensed to practice medicine in this state certifies that such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to the child's health.

8-a. Whenever a child has been refused admission to, or continued attendance at, a school as provided for in subdivision seven of this section because there exists no certificate provided for in subdivision five of this section or other acceptable evidence of the child's immunization against poliomyelitis, mumps, measles, diphtheria, rubella, varicella, hepatitis B, pertussis, tetanus, and, where applicable, Haemophilus influenzae type b (Hib), meningococcal disease, and pneumococcal disease, the principal, teacher, owner or person in charge of the school shall:

a. forward a report of such exclusion and the name and address of such child to the local health authority and to the person in parental relation to the child together with a notification of the responsibility of such person under subdivision two of this section and a form of consent as prescribed by regulation of the commissioner, and

b. provide, with the cooperation of the appropriate local health authority, for a time and place at which an immunizing agent or agents shall be administered, as required by subdivision two of this section, to a child for whom a consent has been obtained. Upon failure of a local health authority to cooperate in arranging for a time and place at which an immunizing agent or agents shall be administered as required by subdivision two of this section, the commissioner shall arrange for such administration and may recover the cost thereof from the amount of state aid to which the local health authority would otherwise be entitled.

10. The commissioner may adopt and amend rules and regulations to effectuate the provisions and purposes of this section.

11. Every school shall annually provide the commissioner, on forms provided by the commissioner, a summary regarding compliance with the provisions of this section.

§ 2165. Immunization of certain post-secondary students. 1. As used in this section, unless the context requires otherwise:

a. The term "institution" means a college as defined in section two of the education law.

b. The term "student" means any person born on or after January first, nineteen hundred fifty-seven, who is registered to attend or attends classes at an institution, whether full-time or part-time. "Part-time student" shall mean a student who is enrolled for at least six but less than twelve semester hours, or the equivalent per semester or at least four but less than eight semester hours per quarter at an institution.

c. The term "health practitioner" means any person authorized by law to administer an immunization.

d. The term "immunization" means an adequate dose or doses of an immunizing agent against measles, mumps and rubella in accordance with regulations issued by the commissioner, utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the Advisory Committee on Immunization Practices, and/or other similar nationally or internationally recognized scientific organizations.

2. Each student at an institution shall provide to the institution a certificate from a health practitioner or other acceptable evidence of such student's immunization, unless such student presents a certificate under subdivision eight of this section or is exempt under subdivision eight-a or nine of this section. Upon compliance, no student shall be denied attendance at an institution because of the requirements of this

section.

3. A student who has not complied with subdivision two of this section shall present himself or herself to a health practitioner and request such practitioner to administer such immunization.

4. If any person is unable to pay for the services of a private health practitioner, such person shall present himself or herself to the health officer of the county in which such person resides, or the county in which the institution is located who shall then administer the immunization without charge.

5. The health practitioner who administers such immunization to any such person shall give a certificate of such immunization to such person.

6. In the event that a student registers at an institution and has not complied with subdivision two of this section, the institution shall inform such student of the necessity to be immunized, that such immunization may be administered by any health practitioner, or that the student may be immunized without charge by the health officer in the county where the student resides or in which the institution is located. In the event that such student does not comply with this section, he or she shall be given notice that attendance at the institution requires immunization unless a valid reason is provided by such student pursuant to subdivision eight or nine of this section.

7. No institution shall permit any student to attend such institution in excess of thirty days without complying with subdivision two of this section. However, such thirty day period may be extended to not more than forty-five days for a student where such student is from out-of-state or from another country and can show a good faith effort to comply with subdivision two of this section.

8. If any licensed physician or nurse practitioner certifies that such immunization may be detrimental to the person's health or is otherwise medically contraindicated, the requirements of this section shall be

inapplicable until such immunization is found no longer to be detrimental to such person's health or is no longer medically contraindicated.

8-a. Proof of discharge from the armed services within ten years from the date of application to an institution shall qualify as a certificate enabling a student to attend the institution pending actual receipt of immunization records from the armed services. If while awaiting the receipt of actual immunization records a health risk shall arise at an institution, a student presenting a certificate under the terms of this subdivision shall be removed from the institution if proper immunization cannot be proved or otherwise rectified.

9. This section shall not apply to a person who holds genuine and sincere religious beliefs which are contrary to the practices herein required, and no certificate shall be required as a prerequisite to such person being admitted or received into or attending an institution.

10. The institution shall provide annually to the commissioner, on forms provided by the commissioner, a summary regarding compliance with this section.

11. The commissioner may adopt and amend rules and regulations to effectuate the provisions and purposes of this section.

13. a. Prior to August first, nineteen hundred ninety-one, this section shall not apply to (i) part-time students or (ii) any student who attended the institution he or she is attending prior to August first, nineteen hundred eighty-nine.

b. Prior to August first, nineteen hundred ninety-one, the thirty and forty-five day periods referred to in subdivision seven of this section shall be deemed to be sixty and ninety days, respectively.

§ 2166. Immunization; regulations. The commissioner may promulgate regulations with respect to immunization conducted by a home care

services agency licensed pursuant to section thirty-six hundred five of this chapter or certified pursuant to section thirty-six hundred eight of this chapter, facilities or institutions established under article twenty-eight of this chapter, and other health care providers and practitioners, including, but not limited to, standards for the quality of care and services provided, consistent with the education law.

§ 2167. Immunization against meningococcal meningitis. 1. As used in this section, unless the context requires otherwise:

a. The term "student" means a person attending an institution and, in the case of a student attending college, "student" means a person who is registered to attend or who attends classes at an institution, who is enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter.

b. The term "institution" means an academy or college, as defined in section two of the education law, or a children's overnight camp as defined in section one thousand three hundred ninety-two of this chapter, where the person attending such camp remains overnight for a period of not fewer than seven days.

c. The term "immunization" means an adequate dose or doses of an immunizing agent against meningococcal meningitis in accordance with regulations issued by the commissioner, utilizing generally accepted medical standards and taking into consideration recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the Advisory Committee on Immunization Practices, and/or other similar nationally or internationally recognized scientific organizations.

2. Each institution shall distribute, in a form provided or approved by the commissioner, written information about meningococcal meningitis and meningitis immunization to all students. The information provided by the institution shall include, but not be limited to, the following:

- a. a description of the disease and means of transmission;
- b. the benefits, risks, and effectiveness of immunization;
- c. the availability and cost of immunization, including an indication of whether or not the institution offers meningococcal meningitis immunization services.

3. Each institution shall also distribute, in a form provided or approved by the commissioner of health, a response form, to be completed by the student or, where the student is under the age of eighteen years, such student's parent or guardian, which shall include the following:

- a. The student, or if under the age of eighteen years the parent or guardian of the student, certifies that the student has already received immunization against meningococcal meningitis within the ten years preceding the date of the response form;

- b. The student, or if under the age of eighteen years the parent or guardian of such student, has received and reviewed the information provided by the institution, understands the risks of meningococcal meningitis and the benefits of immunization, and has decided that the student shall not obtain immunization against meningococcal meningitis.

The student, or if under the age of eighteen years the parent or guardian of such student, shall indicate his or her decision in a box or space placed appropriately on the form and shall return the completed form to the institution. Nothing in this subdivision shall be construed to prohibit an institution from incorporating the form required by this subdivision into another health certificate or form required by the institution.

4. Each institution shall maintain completed response forms.

5. No institution shall permit any student to attend the institution in excess of thirty days without complying with this section; provided,

however, that such thirty day period may be extended to not more than sixty days if a student can show a good faith effort to comply with this section.

6. Nothing in this section shall be construed to prohibit institutions from adopting or maintaining more stringent policies regarding immunization against meningococcal meningitis.

§ 2168. Statewide immunization information system. 1. The department is hereby directed to establish a statewide automated and electronic immunization information system that will serve, and shall be administered consistent with, the following public health purposes:

(a) collect reports of immunizations and thus reduce the incidence of illness, disability and death due to vaccine preventable diseases and collect results of blood lead analyses performed by physician office laboratories to provide to the statewide registry of lead levels of children established pursuant to section thirteen hundred seventy-a of this chapter;

(b) establish the public health infrastructure necessary to obtain, collect, preserve, and disclose information relating to vaccine preventable disease as it may promote the health and well-being of all children in this state;

(c) make available to an individual, or parents, guardians, or other person in a custodial relation to a child or, to local health districts, local social services districts responsible for the care and custody of children, health care providers and their designees, schools, WIC programs, and third party payers the immunization status of children; and

(d) appropriately protecting the confidentiality of individual identifying information and the privacy of persons included in the statewide immunization information system and their families.

2. For the purposes of this section:

(a) The term "authorized user" shall mean any person or entity authorized to provide information to or to receive information from the statewide immunization information system and shall include health care

providers and their designees, as defined in paragraph (d) of this subdivision, schools as defined in paragraph a of subdivision one of section twenty-one hundred sixty-four of this title, colleges as defined in section two of the education law, professional and technical schools as referred to in the definition of higher education in section two of the education law, children's overnight camps and summer day camps as defined in section thirteen hundred ninety-two of this chapter, third party payer as defined in paragraph (f) of this subdivision, local health districts as defined by paragraph (c) of subdivision one of section two of this chapter, local social services districts and the office of children and family services with regard to children in their legal custody, WIC programs as defined in paragraph (g) of this subdivision, registered professional nurses, and pharmacists authorized to administer immunizations pursuant to subdivision two of section sixty-eight hundred one of the education law. An authorized user may be located outside New York state. An entity other than a local health district shall be an authorized user only with respect to a person seeking or receiving a health care service from the health care provider, a person enrolled or seeking to be enrolled in the school, a person insured by the third party payer, a person in the custody of the local social services district or the office of children and family services, or a person seeking or receiving services through WIC programs, as the case may be.

(b) The term "statewide immunization information system" or "system" shall mean a statewide-computerized database maintained by the department capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons under nineteen years of age.

(c) The term "citywide immunization registry" shall mean the computerized database maintained by the city of New York department of health and mental hygiene capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons less than nineteen years of age. The term "citywide immunization registry" shall not include the childhood blood lead registry established pursuant to the health code of the city of New York. For the purposes of this section the term New York city department of health and mental hygiene, shall mean such agency or any successor agency

responsible for the citywide immunization registry.

(d) The term "health care provider" shall mean any person authorized by law to order an immunization or analysis of a blood sample for lead or any health care facility licensed under article twenty-eight of this chapter or any certified home health agency established under section thirty-six hundred six of this chapter; with respect to a person seeking or receiving a health care service from the health care provider.

(e) For purposes of this section a school is a public health authority, as defined in section 164.501 of part 45 of the federal code of rules, responsible for screening the immunization status of each child pursuant to section twenty-one hundred sixty-four of this article.

(f) The term "third party payer" shall mean health maintenance organizations certified under article forty-four of this chapter, health service corporations licensed pursuant to article forty-three of the insurance law, self-insured plans that pay for health care services, health insurance companies subject to article thirty-two of the insurance law which offer preferred provider products, corporations subject to article forty-three of the insurance law which offer preferred provider products, municipal cooperative health benefit plans certified pursuant to article forty-seven of the insurance law which offer preferred provider products, and preferred provider organizations as defined in section three hundred fifty-two of the workers' compensation law.

(g) For purposes of this section the term "WIC program" shall mean a state or local agency, as described pursuant to section 1786 of title 42 of the United States Code.

(h) The term "physician office laboratory" shall mean a laboratory operated by a health care provider pursuant to subdivision one of section five hundred seventy-nine of this chapter that is certified by the Centers for Medicare and Medicaid Services under regulations implementing the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA).

3. (a) (i) Any health care provider who administers any vaccine to a person less than nineteen years of age or, on or after September first, two thousand nine, conducts a blood lead analysis of a sample obtained from a person under eighteen years of age in accordance with paragraph

(h) of subdivision two of this section; and immunizations received by a person less than nineteen years of age in the past if not already reported, shall report all such immunizations and the results of any blood lead analysis to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations or of obtaining the results of any such blood lead analysis. Health care providers administering immunizations to persons less than nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry. Health care providers who conduct a blood lead analysis on a person under eighteen years of age and who report the results of such analysis to the city of New York commissioner of health and mental hygiene pursuant to New York city reporting requirements shall be exempt from this requirement for reporting blood lead analysis results to the state commissioner of health; provided, however, blood lead analysis data collected from physician office laboratories by the commissioner of health and mental hygiene of the city of New York pursuant to the health code of the city of New York shall be provided to the department in a format prescribed by the commissioner.

(ii) A pharmacist who administers a vaccine pursuant to subdivision two of section sixty-eight hundred one of the education law, to a person less than nineteen years of age, shall report all such immunizations to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations. Pharmacists administering immunizations pursuant to subdivision two of section sixty-eight hundred one of the education law to persons less than nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry.

(b) (i) Any health care provider who administers any vaccine to a person nineteen years of age or older, may report, with the consent of the vaccinee, all such immunizations to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations. Health care providers administering immunizations to persons nineteen years of age or older in the city of New York may report, with the consent of the vaccinee, in a format prescribed by the

city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry.

(ii) A registered professional nurse, or a pharmacist who administers a vaccine pursuant to subdivision two of section sixty-eight hundred one of the education law, to a person nineteen years of age or older, shall report, with the consent of the vaccinee, all such immunizations to the department in a format prescribed by the commissioner within fourteen days of administration of such immunizations. Registered professional nurses or pharmacists administering immunizations pursuant to subdivision two of section sixty-eight hundred one of the education law, to persons nineteen years of age or older in the city of New York shall report, with the consent of the vaccinee, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry.

(c) The statewide immunization information system shall provide a method for health care providers to determine when the registrant is due or late for a recommended immunization and shall serve as a means for authorized users to receive prompt and accurate information, as reported to the system, about the vaccines that the registrant has received.

4. (a) All information maintained by the department, or in the case of the citywide immunization registry, the city of New York under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

(b) The department and for the city of New York the department of health and mental hygiene may also disclose or provide such information to an authorized user when (i) such person or agency provides sufficient identifying information satisfactory to the department to identify such registrant and (ii) such disclosure or provision of information is in the best interests of the registrant or his or her family, or will contribute to the protection of the public health.

(c) Any data collected by the department may be included in the statewide immunization information system and the statewide registry of lead levels of children if collection, storage and access of such data is otherwise authorized. Such data may be disclosed to the statewide immunization information system only if provided for in statute or

regulation, and shall be subject to any provisions in such statute or regulation limiting the use or redisclosure of the data. Nothing contained in this paragraph shall permit inclusion of data in the statewide immunization information system if that data could not otherwise be accessed or disclosed in the absence of the system. For the city of New York the commissioner of health and mental hygiene may include data collected in the citywide immunization registry as provided in this paragraph.

(c-1) The department may require the collection of, maintenance and access to newborn infant hearing screening data and results through the statewide immunization information system in accordance with section twenty-five hundred-g of this chapter.

(d) A person, institution or agency to whom such immunization information is furnished or to whom, access to records or information has been given, shall not divulge any part thereof so as to disclose the identity of such person to whom such information or record relates, except insofar as such disclosure is necessary for the best interests of the person or other persons, consistent with the purposes of this section.

5. (a) All health care providers and their designees, except for providers reporting to the citywide immunization registry, shall submit to the commissioner information about any vaccinee less than nineteen years of age and about each vaccination given after January first, two thousand eight. The information provided to the system or the citywide immunization registry shall include the national immunization program data elements and other elements required by the commissioner. For the city of New York the commissioner of health and mental hygiene may require additional elements with prior notice to the commissioner of any changes.

(b) In addition to the immunization administration information required by this section, the operation of any immunization registry established under chapter five hundred twenty-one of the laws of nineteen hundred ninety-four, section 11.07 of title twenty-four of volume eight of the compilation of the rules of the city of New York and administered by a local health district collecting information from health care providers about vaccinations previously administered to a

vaccinee prior to the effective date of this section shall provide the commissioner access to such information.

(c) All health care providers shall provide the department or, as appropriate, the city of New York with additional or clarifying information upon request reasonably related to the purposes of this section.

(d) Notwithstanding the above, submission of incomplete information shall not prohibit entry of incomplete but viable data into the statewide immunization information system.

(e) The commissioner of the department of health and mental hygiene for the city of New York shall implement the requirements of this subdivision.

(f) The immunization status of children exempt from immunizations pursuant to subdivision eight of section twenty-one hundred sixty-four of this title shall be reported by the health care provider.

6. In the city of New York, the commissioner of the department of health and mental hygiene of the city of New York may maintain its existing registry consistent with the requirements of this section and shall provide information to the commissioner and to authorized users.

7. Each parent or legal guardian of a newborn infant or a child newly enrolled in the statewide immunization information system shall receive information, developed by the department, describing the enrollment process and how to review and correct information and obtain a copy of the child's immunization record. The city of New York will be responsible for providing information about the processes for enrollment and access to the citywide immunization registry by a parent or legal guardian of a newborn infant or newly enrolled child residing in the city of New York.

8. Access and use of identifiable registrant information shall be limited to authorized users consistent with this subdivision and the purposes of this section. (a) The commissioner shall provide a method by which authorized users apply for access to the system. For the city of New York, the commissioner of health and mental hygiene shall provide a method by which authorized users apply for access to the citywide

immunization registry.

(b) (i) The commissioner may use the statewide immunization information system and the blood lead information in such system for purposes of outreach, quality improvement and accountability, including professional responsibility proceedings of the office of professional medical conduct and the state education department, research, epidemiological studies and disease control, and to obtain blood lead test results from physician office laboratories for the statewide registry of lead levels of children established pursuant to subdivision two of section thirteen hundred seventy-a of this chapter; (ii) the commissioner of health and mental hygiene for the city of New York may use the immunization registry and the blood lead information in such system for purposes of outreach, quality improvement and accountability, research, epidemiological studies and disease control; (iii) local health departments shall have access to the immunization information system and the blood lead information in such system for purposes of outreach, quality improvement and accountability, epidemiological studies and disease control within their county; and

(c) health care providers and their designees, registered professional nurses, and pharmacists authorized to administer immunizations pursuant to subdivision two of section sixty-eight hundred one of the education law shall have access to the statewide immunization information system and the blood lead information in such system only for purposes of submission of information about vaccinations received by a specific registrant, determination of the immunization status of a specific registrant, determination of the blood lead testing status of a specific registrant, submission of the results from a blood lead analysis of a sample obtained from a specific registrant in accordance with paragraph (h) of subdivision two of this section, review of practice coverage, generation of reminder notices, quality improvement and accountability, including professional responsibility proceedings of the office of professional medical conduct and the state education department, and printing a copy of the immunization or lead testing record for the registrant's medical record, for the registrant's parent or guardian, or other person in parental or custodial relation to a child, or for a registrant upon reaching eighteen years of age.

(d) The following authorized users shall have access to the statewide

immunization information system and the blood lead information in such system and the citywide immunization registry for the purposes stated in this paragraph: (i) schools for the purpose of verifying immunization status for eligibility for admission, for the purpose of confirming a student has been screened for lead when enrolling in child care, pre-school, pre-kindergarten or kindergarten, and for the provision of appropriate educational materials developed by the department pursuant to section thirteen hundred seventy-a of this chapter on the dangers of lead exposure, and the health risks associated with elevated blood lead levels to the parents or legal guardians of the student with an elevated blood lead level, as such term is defined in subdivision six of section thirteen hundred seventy of this chapter, as well as information on programs that may be available to the student and the parents or legal guardians of the student. For each school that has the technical ability to batch download sets of immunization records, the department shall make available such sets of immunization records of only those children submitted by the school for which the school has obtained a certificate of immunization or for which the school has responsibility to verify the immunization status for school attendance purposes under section twenty-one hundred sixty-four of this article. Schools shall properly safeguard such information for use only as authorized by this section; (ii) colleges for verifying immunization status for eligibility for admission; (iii) professional and technical schools for verifying immunization status for eligibility for admission; (iv) children's overnight camps and summer day camps for verifying immunization status of children attending camp; (v) third party payer for performing quality assurance, accountability and outreach, relating to enrollees covered by the third party payer; (vi) commissioners of local social services districts with regard to a child in his/her legal custody; (vii) the commissioner of the office of children and family services with regard to children in their legal custody, and for quality assurance and accountability of commissioners of local social services districts, care and treatment of children in the custody of commissioners of local social services districts; and (viii) WIC programs for the purposes of verifying immunization and lead testing status for those seeking or receiving services.

(e) Institutes of higher education, medical research centers or other

institutions engaged in epidemiological research or other public health research shall have access to de-identified registrant information in the statewide immunization information system or the citywide immunization registry for research purposes if approved by the commissioner or the commissioner of the department of health and mental hygiene of the city of New York, as appropriate.

9. The commissioner may judge the legitimacy of any request for immunization system information and may refuse access to the statewide immunization information system based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation. For the city of New York the commissioner of health and mental hygiene may judge the legitimacy of requests for access to the citywide immunization registry and refuse access to the immunization registry based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation.

10. The person to whom any immunization record relates, or his or her parent, or guardian, or other person in parental or custodial relation to such person may request a copy of an immunization or lead testing record from the registrant's healthcare provider, the statewide immunization information system or the citywide immunization registry according to procedures established by the commissioner or, in the case of the citywide immunization registry, by the city of New York commissioner of the department of health and mental hygiene.

11. The commissioner, or in the city of New York, the commissioner of the department of health and mental hygiene, may provide registrant specific immunization and lead test records to the federal centers for disease control and prevention or its successor agency, to other state or city registries and registries maintained by the Indian Health Service and tribal nations recognized by the state or the United States pursuant to a written agreement requiring that the other registry conform to national standards for maintaining the integrity of the data and that the data will only be used for purposes consistent with the provisions of this section and provided that disclosure of identifiable registrant information shall be limited to the minimum amount necessary

to accomplish the purposes consistent with the provisions of this section as determined by the commissioner, or in the city of New York, the commissioner of the department of health and mental hygiene.

11-a. The commissioner, or in the city of New York, the commissioner of the department of health and mental hygiene, may only share registry information maintained by the department, or in the case of the citywide immunization registry, the city of New York under the provisions of this section with the federal Centers for Disease Control and Prevention, or successor agency, for public health purposes in summary, statistical, aggregate, or other form such that no individual person can be identified, except that either such commissioner may disclose identifiable registrant information to the federal Centers for Disease Control and Prevention, or its successor agency, when the commissioner has determined that the disclosure is in the best interests of the registrant or will contribute to the protection of public health and that the objective of the disclosure cannot be served by disclosure limited to de-identified information, or the federal health officials have committed in writing not to redisclose to or share registrant information with any other federal agency, including but not limited to the department of homeland security, immigration and customs enforcement, customs and border protection, or any successor agency, or any law enforcement agency; provided that either such commissioner may forgo the written commitment if requiring written commitment would result in the actual withholding of federal funds.

12. Information that would be provided upon the enrollment in the statewide immunization information system of a child being vaccinated, from birth records of all infants born in New York state on or after January first, two thousand four shall be entered into the statewide immunization information system, except in the city of New York, where birth record information shall be entered into the citywide immunization registry.

13. The commissioner shall promulgate regulations as necessary to effectuate the provisions of this section. Such regulations shall include provision for orderly implementation and operation of the

statewide immunization information system, including the method by which each category of authorized user may access the system. Access standards shall include at a minimum a method for assigning and authenticating each user identification and password assigned.

14. No authorized user shall be subjected to civil or criminal liability, or be deemed to have engaged in unprofessional conduct for reporting to, receiving from, or disclosing information relating to the statewide immunization information system when made reasonably and in good faith and in accordance with the provisions of this section or any regulation adopted thereto.

§ 2169. Vaccine confidentiality. 1. As used in this section, unless context requires otherwise:

(a) The term "consent" shall mean informed, affirmative, and voluntary authorization.

(b) The term "de-identified" shall mean that the information cannot identify or be made to identify or be associated with a particular individual, directly or indirectly, and is subject to technical safeguards and policies and procedures that prevent re-identification, whether intentionally or unintentionally, of any individual.

(c) The term "disclosure" shall mean release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

(d) The term "immigration authority" means any entity, officer, employee, or government employee or agent thereof charged with or engaged in enforcement of the federal Immigration and Nationality Act, including the United States Immigration and Customs Enforcement, United States Department of Homeland Security, or United States Customs and Border Protection, or agent, contractor, or employee thereof, or any successor legislation or entity.

(e) The term "law enforcement agent or entity" means any governmental entity or public servant, or agent, contractor or employee thereof, authorized to investigate, prosecute, or make an arrest for a criminal or civil offense, or engaged in any such activity, but shall not mean the department, the commissioner, a health district, a county department

of health, a county health commissioner, a local board of health, a local health officer, the department of health and mental hygiene of the city of New York, or the commissioner of the department of health and mental hygiene of the city of New York.

(f) The term "personal information" shall mean information obtained from or about an individual, in connection with their registering for a vaccination, that directly or indirectly identifies, relates to, describes, is capable of being associated with, or could reasonably be linked to a particular individual, household, or personal device. Information is reasonably linkable to an individual, household, or personal device if it can be used on its own or in combination with other reasonably available information, when such information is held by the vaccine navigator, to identify an individual, household, or a personal device.

(g) The term "service attendant to the delivery of immunization" shall mean facilitating an immunization appointment, sending reminders about immunization, arranging transportation to or from a vaccine provider, or reporting to the department, the New York City department of health and mental hygiene, or other local health agency on whose behalf such vaccine navigator is performing such services.

(h) The term "use" shall mean, with respect to personal information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

(i) The term "vaccine navigator" shall mean any person that collects personal information from an individual in order to register that individual for immunization or to help that individual register for immunization, provided the department, a local public health agency, or a person that administers vaccines or their designees are not vaccine navigators.

2. (a) Except as provided in paragraph (d) of this subdivision, absent consent from the individual seeking immunization, or if the individual lacks the capacity to make health care decisions, an individual authorized to consent to health care for the individual or the individual's legal representative, a vaccine navigator shall not use, disclose, or maintain personal information except as necessary to

provide services attendant to the delivery of immunization.

(b) A vaccine navigator may request consent from an individual, or if the individual lacks the capacity to make health care decisions, an individual authorized to consent to health care for the individual or the individual's legal representative, to use, disclose, or maintain the individual's personal information for purposes other than services attendant to the delivery of immunization provided that:

(i) a vaccine navigator shall not refuse to provide a service attendant to the delivery of immunization for an individual who does not provide such consent;

(ii) a vaccine navigator shall not relate the price or quality of any service attendant to the delivery of immunization to the privacy protections afforded the individual, including by providing a discount or other incentive in exchange for such consent, provided that this paragraph does not prohibit the offering of incentives to individuals to get vaccinated; provided that such incentives shall not be conditioned on an individual's consent to additional uses, disclosures, or maintenance of their personal information except as necessary to provide the incentive; and

(iii) a vaccine navigator shall clearly delineate what personal information is adequate, relevant, and necessary to provide a service attendant to the delivery of immunization by clearly and conspicuously indicating in any solicitation for the information that all other requests for personal information are optional.

(c) Except as provided in paragraph (d) of this subdivision:

(i) No vaccine navigator may provide personal information or otherwise make personal information accessible, directly or indirectly, to a law enforcement agent or entity or immigration authority;

(ii) No vaccine navigator may provide personal information or otherwise make personal information accessible, directly or indirectly, to any other individual or entity, except as explicitly authorized by this title; and

(iii) Without consent under this subdivision, personal information and any evidence derived therefrom shall not be subject to or provided in response to any legal process or be admissible for any purpose in any judicial or administrative action or proceeding unless provided in response pursuant to warrants, court-ordered subpoenas, administrative

subpoenas, or grand jury subpoenas.

(d) (i) This section does not bar otherwise lawful disclosure, possession or use of information pertaining to services attendant to the delivery of immunization, including aggregate information, that is de-identified. Disclosure, possession or use under this subparagraph shall only be for a public health or public health research purposes.

(ii) A vaccine navigator may only possess or use de-identified information pertaining to services attendant to the delivery of immunization if the vaccine navigator maintains technical safeguards and policies and procedures that prevent re-identification, whether intentional or unintentional, of any individual, as may be required by the commissioner (or the New York city commissioner of health and mental hygiene, in the case of information collected by or under authority of the New York city department of health and mental hygiene. The commissioner (or the New York city commissioner as the case may be) shall require safeguards, policies and procedures under this paragraph as the commissioner deems practicable.

(iii) Disclosure, possession and use of de-identified information under this subdivision shall be only pursuant to approval by the commissioner (or the New York city commissioner of health and mental hygiene in the case of information collected by or under authority of the New York city department of health and mental hygiene) specifying the purpose, nature and scope of the disclosure, possession and use and measures to ensure that it will comply with this section and the terms of the approval.

(e) A vaccine navigator that maintains personal information shall establish appropriate administrative, technical, and physical safeguards, policies, and procedures that ensure the security of that personal information. The safeguards, policies, and procedures must be appropriate to the volume and nature of the personal information maintained and the size, revenue, and sophistication of the vaccine navigator and must ensure that personal information is encrypted and protected at least as much as or more than other confidential information in the vaccine navigator's possession. The commissioner or, in the city of New York, the commissioner of the department of health and mental hygiene may make regulations as reasonably necessary to require that personal information possessed, used, or under the control

of a vaccine navigator shall be subject to technical safeguards, policies, and procedures for storage, transmission, use, and protection of the information. The regulations must take into account the different sizes, revenues and sophistications of different vaccine navigators, as well as the volume and nature of the personal information they maintain.

(f) Nothing in this section shall limit a vaccine navigator that has a pre-existing service provider-client, provider-patient, or familial relationship or a friendship with an individual from processing that individual's personal information as previously agreed to in the course of the pre-existing relationship.

3. Vaccine providers. A vaccine provider shall not delay or condition the provision of any service attendant to the delivery of immunization by inviting or requiring an individual seeking vaccination to complete an application for a customer discount card or account or share personal information that will be stored outside of a record protected under the federal Health Insurance Portability and Accountability Act of 1996, its implementing regulations, or section eighteen of this chapter for purposes other than services attendant to the delivery of immunization, or by engaging in any other activity unrelated to the provision of such a service that the commissioner designates by regulation.

TITLE VII

HEPATITIS C

Section 2170. Hepatitis C; educational materials.

2171. Required offering of hepatitis C screening testing.

§ 2170. Hepatitis C; educational materials. The commissioner shall develop and make available to physicians, other health care providers, veterans and other persons at high risk for hepatitis C educational materials, in written and electronic forms, on the diagnosis, treatment and prevention of hepatitis C. Such materials shall include the recommendations of the federal Centers for Disease Control and Prevention and any other person or entity having knowledge on hepatitis C, including the American Liver Foundation. Such materials shall be

written in terms which are understandable by members of the general public.

*** § 2171. Required offering of hepatitis C screening testing. 1.**

Every individual age eighteen and older (or younger than eighteen if there is evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in subdivision ten of section twenty-eight hundred one of this chapter or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under article twenty-eight of this chapter or from a physician, physician assistant, nurse practitioner or midwife providing primary care shall be offered a hepatitis C screening test unless the health care practitioner providing such services reasonably believes that:

(a) the individual is being treated for a life threatening emergency; or

(b) the individual has previously been offered or has been the subject of a hepatitis C screening test (except that a test shall be offered if otherwise indicated); or

(c) the individual lacks capacity to consent to a hepatitis C screening test.

2. If an individual accepts the offer of a hepatitis C screening test and the screening test is reactive, an HCV RNA test must be performed, on the same specimen or a second specimen collected at the same time as the initial HCV screening test specimen, to confirm diagnosis of current infection. The health care provider shall either offer all persons with a detectable HCV RNA test follow-up HCV health care and treatment or refer the individual to a health care provider who can provide follow-up HCV health care and treatment.

3. The offering of hepatitis C screening testing under this section shall be culturally and linguistically appropriate in accordance with rules and regulations promulgated by the commissioner.

4. This section shall not affect the scope of practice of any health

care practitioner or diminish any authority or legal or professional obligation of any health care practitioner to offer a hepatitis C screening test or hepatitis C diagnostic test or to provide services or care for the subject of a hepatitis C screening test or hepatitis C diagnostic test.

5. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Hepatitis C diagnostic test" shall mean any laboratory test or tests that detect the presence of hepatitis C virus in the blood and provides confirmation of whether the individual has a hepatitis C virus infection.

(b) "Hepatitis C screening test" shall mean any laboratory screening test or tests that detect the presence of hepatitis C virus antibodies in the blood.

(c) "Primary care" means the medical fields of family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification.

* NB Repealed January 1, 2030

TITLE 8

NOVEL CORONAVIRUS, COVID-19

Section 2180. Definitions.

2181. COVID-19 contact tracing; confidentiality.

2182. Regulations.

2183. Immunity passports.

§ 2180. Definitions. As used in this title the following terms shall have the following meanings:

1. "Contact tracing" means COVID-19 case investigation and identification of case individuals and contact individuals.

2. (a) "Contact tracer" and "contact tracing entity" means an

individual or entity employed by or under contract with the state, a local government, a state or local governmental entity, or an agent thereof, to conduct contact tracing, engage in contact tracing, or receive contact tracing information.

(b) A contact tracer or contact tracing entity shall not include a service provider that is a non-governmental entity that is employed by or under contract with a contact tracing entity or an agent thereof, that receives, transmits, maintains, stores, or hosts contact tracing information at the direction of a contact tracer or contact tracing entity so long as such service provider's access to the information is exclusively limited to the maintenance of the information and the contact tracer or contact tracing entity has the ability to delete and manage contact tracing information as provided by this chapter, law, rules or regulations. A service provider under this paragraph shall be referred to in this title as a "designated non-governmental entity." A service provider that does not meet the requirements of this paragraph and would otherwise be subject to paragraph (a) of this subdivision shall be a contact tracing entity.

3. "Contact tracing information" means any information that includes or can reveal the identity of any case individual or contact individual, and any COVID-19-related information or test results, received or collected for the purpose or in the course of contact tracing.

4. "Contact individual" means an individual who has or may have come in contact with a case individual or who has or may have been exposed to and possibly infected with COVID-19.

5. " Case individual" means an individual with a confirmed or probable diagnosis of COVID-19.

6. "COVID-19" means infection with or the disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

7. "Immigration authority" means any entity, officer, employee, or government employee or agent thereof charged with or engaged in enforcement of the federal Immigration and Nationality Act, including

the United States Immigration and Customs Enforcement, United States Department of Homeland Security, or United States Customs and Border Protection, or agent, contractor or employee thereof, or any successor legislation or entity.

8. "De-identified" means, in relation to contact tracing information, that the information cannot identify or be made to identify or be associated with a particular individual, directly or indirectly and is subject to technical safeguards and policies and procedures that prevent re-identification, whether intentionally or unintentionally, of any individual.

9. "Law enforcement agent or entity" means any governmental entity or public servant, or agent, contractor or employee thereof, authorized to investigate, prosecute, or make an arrest for a criminal or civil offense (except a designated civil offense), or engaged in any such activity, but shall not mean the department, the commissioner, a health district, a county department of health, a county health commissioner, a local board of health, a local health officer, the department of health and mental hygiene of the city of New York, or the commissioner of the department of health and mental hygiene of the city of New York. As used in this subdivision, "designated civil offense" means a civil offense or offenses designated by the commissioner (or the commissioner of the New York city department of health and mental hygiene in the case of contact tracing information collected by or under authority of the New York city department of health and mental hygiene or the New York city health and hospitals corporation).

10. "Support" means resources or services provided to an individual to enable such individual to safely quarantine or isolate, including grocery, meal or pharmacy delivery, laundry services, child or elder care, pet walking, assistance with telephone, internet, or other communication services or devices, health and mental health services, legal services, provision of appropriate living space for individuals who cannot isolate or quarantine at home, and income replacement. "Support" may also include support provided to other individuals for whom the individual commonly provides those resources or services.

11. "Permitted purpose" means:

(a) disclosure to appropriate health care providers or their personnel for the purpose of the clinical diagnosis, care or treatment of the case individual or contact individual who is the subject of the information, where an emergency exists and the individual is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the individual's life or health;

(b) facilitating a legally-authorized public health-related action, where and only to the extent necessary to protect the public health in relation to COVID-19; or

(c) use or disclosure of contact tracing information to pursue a legal action in relation to a violation of this title; provided that disclosure shall be subject to in camera review and approval by the court, and, if the use is initiated by a party other than the case individual or contact individual who is the subject of the contact tracing information, the information must be highly material and relevant for the purpose.

12. "Covered entity" means a governmental entity or a place of public accommodation, resort or amusement, as defined in section two hundred ninety-two of the executive law.

13. "Physical immunity passport" means a credential that identifies an individual as having received a COVID-19 vaccine or a COVID-19 test result that does not rely on a digital or electronic device. Physical immunity passports include, but are not limited to, pieces of paper denoting immunity status.

§ 2181. COVID-19 contact tracing; confidentiality. 1. (a) All contact tracing information shall be kept confidential by any contact tracer, contact tracing entity, or designated non-governmental entity and may not be disclosed except as necessary to carry out contact tracing or a permitted purpose. A designated non-governmental entity may only act in relation to contact tracing information as explicitly authorized by this

title.

(b) Where a contact tracer or contact tracing entity discloses contact tracing information for a permitted purpose, the contact tracer or contact tracing entity shall make a record of the disclosure, including to whom it was made and when it was made, which shall be part of the contact tracing information.

(c) Nothing in this title prohibits otherwise lawful voluntary reporting, at the discretion of the contact tracer, reasonably and in good faith: (i) to the statewide central registry under title six of article six of the social services law, adult protective services under titles one and two of article nine-B of the social services law, or the justice center for the protection of people with special needs under article eleven of the social services law; or (ii) to a governmental or non-governmental emergency reporting system (such as a "911," domestic violence or suicide prevention system) to prevent imminent risk of injury to any person.

(d) This title does not limit disclosure to or by, or possession or use by, the case individual or contact individual who is the subject of the information.

2. (a) An individual may waive the confidentiality provided for by this section, only by a written, informed and voluntary waiver, in plain language and in a language understandable to the individual making the waiver, and not part of any other document. The waiver shall state the scope and limit of the waiver. No contact tracer, contact tracing entity or governmental or non-governmental entity may seek or act in reliance on a waiver to distribute, sell, or otherwise disclose identifiable or de-identified data to any individual or entity. Provided however, nothing in this subdivision shall prohibit distribution or disclosure that is otherwise explicitly authorized by this section. If an individual lacks the capacity to make a waiver, an individual authorized to consent to health care for the individual, or the individual's legal representative, may make the waiver. However, a waiver of confidentiality is not required to be written if it is solely for the purpose of arranging or providing support for the individual who is the subject of the contact tracing information, provided the consent is informed and voluntary.

(b) A waiver of confidentiality under this section shall only apply for the purpose of arranging or providing support if the individual who is the subject of the contact tracing information (or, if the individual lacks the capacity to provide informed consent, an individual authorized to consent to health care for the individual, or the individual's legal representative) provides voluntary informed consent to the arranging or providing of the support.

3. A disclosure of contact tracing information authorized under this section shall be limited in scope as to the identity of any individual, the information to be disclosed, and the party to which disclosure may be made, and as necessary to achieve the purpose of the disclosure under this section, and shall not authorize re-disclosure except as explicitly authorized by the terms of the waiver under this section. However, this section does not bar disclosure of contact tracing information pertaining to and identifying a case individual or contact individual by the individual who is identified.

4. (a) This section does not bar otherwise-lawful disclosure, possession or use of de-identified contact tracing information, including aggregate contact tracing information. Disclosure, possession or use under this subdivision shall only be for a public health or public health research or evaluation purpose as determined by the commissioner (or the commissioner of the New York city department of health and mental hygiene in the case of contact tracing information collected by or under authority of the New York city department of health and mental hygiene or the New York city health and hospitals corporation), and shall not authorize re-disclosure or other use.

(b) A person or entity may only disclose, possess or use de-identified contact tracing information if the person or entity, and the person or entity to which it is disclosed, maintains technical safeguards and policies and procedures that prevent re-identification, whether intentional or unintentional, of any individual, as may be required by the commissioner (or the New York city commissioner of health and mental hygiene in the case of contact tracing information collected by or under authority of the New York city department of health and mental hygiene or the New York city health and hospitals corporation). The commissioner

(or the New York city commissioner as the case may be) shall require safeguards, policies and procedures under this paragraph as the commissioner deems practicable.

(c) Disclosure, possession and use of de-identified contact tracing information under this subdivision shall be only pursuant to approval by the commissioner (or the New York city commissioner of health and mental hygiene in the case of contact tracing information collected by or under authority of the New York city department of health and mental hygiene or the New York city health and hospitals corporation) specifying the purpose, nature and scope of the disclosure, possession and use and measures to ensure that it will comply with this section and the terms of the approval.

5. No law enforcement agent or entity or immigration authority shall be a contact tracer or contact tracing entity or engage in contact tracing. This subdivision does not bar an individual who is associated with a law enforcement entity or immigration authority from acting only as a case individual or contact individual. This subdivision does not prevent a law enforcement agent or entity from assisting in a permitted use under paragraph (b) of subdivision eleven of section twenty-one hundred eighty of this title.

6. No contact tracer, contact tracing entity or designated non-governmental entity may provide contact tracing information to a law enforcement agent, entity or immigration authority, or any individual or entity other than the contact tracing entity from which it received the information, except as explicitly authorized by this title. Without consent under subdivision two of this section, contact tracing information and any evidence derived therefrom shall not be subject to or provided in response to any legal process or be admissible for any purpose in any judicial or administrative action or proceeding. However, this subdivision does not restrict providing information, relating to a specified case individual or contact individual, where and only to the extent necessary for a permitted purpose.

7. (a) Contact tracing entities shall establish appropriate administrative, technical and physical safeguards, policies and

procedures that ensure the security of contact tracing information under the entity's jurisdiction. The safeguards, policies and procedures must ensure contact tracing information is encrypted and protected at least as much as or more than other confidential information under the entity's jurisdiction. All storage of contact tracing information shall meet the requirements of this title. The commissioner (or the New York city commissioner of health and mental hygiene in the case of contact tracing information collected by or under authority of the New York city department of health and mental hygiene or the New York city health and hospitals corporation) shall make regulations as reasonably necessary to require that contact tracing information possessed, used or under the control of a contact tracer or contact tracing entity shall be subject to technical safeguards, policies and procedures for storage, transmission, use and protection of the information. The regulations shall prevent possession, use or disclosure of the contact tracing information not permitted by this title, and shall be at least as or more protective than the safeguards, policies and procedures the commissioner (or the New York city commissioner as the case may be) provides for other confidential information.

(b) This paragraph applies to a contact tracer or contact tracing entity that is a non-governmental individual or entity employed by or under contract with a governmental entity, or an agent thereof. Within sixty days of collecting or receiving the contact tracing information, the entity shall (i) remove information from its possession or control and deliver it to the appropriate governmental contact tracing entity or a designated non-governmental entity specified by the governmental contact tracing entity, retaining no copy of it; (ii) expunge the information from its possession or control; or (iii) de-identify the information. However, the expungement or de-identification of particular contact tracing information may be postponed for up to fifteen days after the initial sixty day period while the contact tracer or contact tracing entity is actively engaged in contact tracing using that information, provided that the case individual or contact individual to whom it pertains gives voluntary informed consent. The disclosure, possession and use of the de-identified contact tracing information shall be subject to subdivision four of this section.

§ 2182. Regulations. The commissioner shall make regulations as reasonably necessary to implement this title.

§ 2183. Immunity passports. 1. Any covered entity that requires proof of COVID-19 immunization shall permit the use of physical immunity passports. No covered entity may require digital, electronic, or smartphone-based proof of immunity. Notwithstanding this section, anyone requiring an immunization passport shall accept a valid COVID-19 Vaccination Record Card allocated to COVID-19 vaccine providers by the Centers for Disease Control and Prevention for that purpose. The provisions of this section shall apply to valid COVID-19 Vaccination Record Cards allocated to COVID-19 vaccine providers by the Centers for Disease Control and Prevention.

2. Nothing in this section requires a covered entity to require proof of COVID-19 immunity or to independently verify the information contained in an immunity passport.

3. Nothing in this section shall be construed to limit a covered entity's obligations under the Americans with Disabilities Act, article fifteen of the executive law, the civil rights law, or any other federal, state, or local anti-discrimination law.

4. Nothing in this section shall be construed to affect the practices of a health care provider, as defined in section eighteen of this chapter, a hospital or nursing home as defined in article twenty-eight of this chapter, a health practitioner as defined in section twenty-one hundred sixty-four of this chapter, a facility, as defined in section 33.13 of the mental hygiene law, or a correctional health service governed by the department of corrections and community supervision, the rules of the board of correction in the city of New York, or a county board of correction, with respect to records concerning their patients' vaccinations.

ARTICLE 21-A
**LONG-TERM CARE RESIDENT AND
EMPLOYEE IMMUNIZATION ACT**

Section 2190. Short title.

2191. Definitions.

2192. Long-term care resident and employee immunization required.

2193. Resident immunization.

2194. Employee immunization.

2195. Exceptions.

2196. Rules and regulations; report.

§ 2190. Short title. This article shall be known and may be cited as the "long-term care resident and employee immunization act".

§ 2191. Definitions. For the purposes of this article:

1. "Long-term care facility" or "facility" means a residential health care facility as defined in section twenty-eight hundred one of this chapter, adult home as defined in subdivision twenty-five of section two of the social services law or enriched housing program as defined in subdivision twenty-eight of section two of the social services law, adult day health care program in accordance with regulations of the department, and any other facility providing residential housing for five or more persons over the age of sixty-five unrelated to the operator and supportive services including, but not limited to, food service, housekeeping, laundry, arranging for medical care, and assistance with daily living.

2. "Documentation" means written evidence from an individual's health care provider indicating the date and place when the individual received the influenza vaccine or the pneumococcal vaccine.

3. "Medically contraindicated" means influenza or pneumococcal vaccine should not be administered to an individual because it may be

detrimental to the individual's health if the individual receives the vaccine.

4. "Employee" means an individual employed (whether directly, by contract with another entity or as an independent contractor) by a long-term care facility, on a part-time or full-time basis.

§ 2192. Long-term care resident and employee immunization required.

Except as provided in section twenty-one hundred ninety-five of this article, every long-term care facility in this state shall require residents and employees to be immunized for influenza virus and pneumococcal disease in accordance with regulations of the commissioner.

§ 2193. Resident immunization. 1. Upon admission, a long-term care facility shall notify the resident of the immunization requirements of this article and request that the resident agree to be immunized against influenza virus and pneumococcal disease.

2. Every long-term care facility shall document the annual immunization against influenza virus and immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking such immunization or the long-term care facility or individual is unable to provide documentation that the individual has received the appropriate immunization, the long-term care facility shall provide or arrange for immunization. Immunization and the documentation thereof shall take place no later than November thirtieth of each year.

3. An individual who becomes a resident after November thirtieth but before April first shall have his or her status for influenza and pneumococcal immunization determined by the facility, and if found to be deficient, the facility shall provide or arrange for the necessary immunization.

§ 2194. Employee immunization. 1. Every long-term care facility shall

notify every employee of the immunization requirements of this article and request that the employee agree to be immunized against influenza virus and pneumococcal disease.

2. The long-term care facility shall require documentation of annual immunization against influenza virus and immunization against pneumococcal disease for each employee. Upon finding that an employee is lacking such immunization or the long-term care facility or individual is unable to provide documentation that the individual has received the appropriate immunization, the long-term care facility must provide or arrange for immunization. Immunization and the documentation thereof shall take place no later than November thirtieth of each year.

3. An individual who is newly employed as an employee after November thirtieth but before April first shall have his or her status for influenza and pneumococcal immunization determined by the facility, and if found to be deficient, the facility shall provide or arrange for the necessary immunization.

§ 2195. Exceptions. No individual shall be required to receive either an influenza vaccine or pneumococcal vaccine if the vaccine is medically contraindicated, or if it is against his or her religious beliefs, or if he or she refuses the vaccine after being fully informed of the health risks of such action.

§ 2196. Rules and regulations; report. 1. The commissioner shall promulgate regulations relating to the immunization requirements of this article, taking into consideration the recommendations of the centers for disease control and prevention.

2. The commissioner is hereby directed to make available educational and informational materials to all long-term care facilities with respect to vaccination against influenza virus and pneumococcal disease.

3. The commissioner shall report three years from the effective date

of this article to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate and the minority leader of the assembly on the number of outbreaks in long-term care facilities each year due to influenza virus and pneumococcal disease and number of hospitalizations of long-term care facility residents each year due to influenza virus, pneumococcal disease and complications thereof.

ARTICLE 22

CONTROL OF TUBERCULOSIS

Title I. General provisions (§§ 2200-2207).

II. Control (§§ 2221-2230).

TITLE I

GENERAL PROVISIONS

Section 2200. Tuberculosis; definitions and explanation of terms.

2201. Tuberculosis; powers and duties of commissioner.

2202. Tuberculosis; care and treatment.

2204. Tuberculosis; removal of patients to another state or country; costs.

2205. Tuberculosis; removal of patients to this state; reciprocity agreements.

2206. Tuberculosis; administration costs; appropriations.

2207. Tuberculosis; application of law to city of New York.

§ 2200. Tuberculosis; definitions and explanation of terms. 1. (a) State residence. Under the conditions hereinafter specified, any person who has resided in the state of New York continuously for at least one year immediately preceding the date of admission to a hospital for the care and treatment of tuberculosis shall be deemed to have state residence.

(b) State residence so acquired shall continue until such person shall have removed from the state and remained therefrom for one year; provided, however, that no person shall lose state residence by absence

from the state while serving in the armed forces of the United States or in the United States merchant marine, or while attached to and serving with the armed forces of the United States and, provided, further, that no member of the family of any such person shall lose state residence by absence from the state while living with or near such person during the period of such service and on account thereof.

2. Local residence. Under the conditions hereinafter specified, any person with state residence as herein defined who has also resided within a county of the state or in the city of New York continuously for at least six months preceding the date of admission to a hospital for the care and treatment of tuberculosis shall be deemed to have local residence in such county or in the city of New York, as the case may be.

3. Qualification on residence. The continuous residence required to acquire either state residence or local residence shall not include any period during which the person was (a) a patient in a hospital, or (b) an incarcerated individual of any public institution, incorporated private institution, or private tuberculosis home, cottage or hospital, or (c) residing on any military reservation. If, however, the periods of residence immediately prior and subsequent to the periods specified in (a), (b), or (c) shall together equal the required period of residence, such person shall be deemed to have the required continuous residence.

4. State charge. State charge shall mean any person suffering from tuberculosis or suspected of having tuberculosis and in need of tuberculosis hospital care and treatment therefor who is:

- (a) without state residence;
- (b) with state residence but without local residence;
- (c) an Indian or member of his family residing upon any Indian reservation in the state.

5. Local charge. Local charge shall mean any person suffering from tuberculosis or suspected of having tuberculosis and in need of tuberculosis hospital care and treatment therefor who has acquired local residence, as defined in this article.

§ 2201. Tuberculosis; powers and duties of commissioner. 1. The commissioner shall: (a) formulate such standards as he may deem necessary in order to carry out the objectives and provisions of this article and article six of this chapter relating to state aid for the care and treatment of tuberculous patients;

(b) make a detailed study of the administration of existing public hospitals caring for tuberculous patients throughout the state, including the city of New York;

(c) make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate for the facilities, operation, administration and the future conduct of public hospitals caring for tuberculous patients throughout the state including the city of New York, under the provisions of this article and article six of this chapter, and he may, from time to time, amend or repeal the same;

(d) forward a copy of such rules and regulations to the board of supervisors of each county and to the mayor of each city, eligible for state aid under this article and article six of this chapter;

(e) have full power and authority to examine any or all records, reports and other data pertaining to patients or the facilities, operation or administration of a hospital providing care or treatment of tuberculous patients for which a county or city applies for state aid;

(f) have full power and authority to examine or cause to be examined any patient in a hospital providing care or treatment for which a county or city applies for state aid;

(g) have full power and authority to make or cause to be made such laboratory tests or X-ray examinations as in his judgment may be desirable;

(h) have power and authority to recommend to counties and cities such changes in the facilities, operation or administration of public hospitals caring for tuberculous patients throughout the state, including the city of New York, as, in his judgment, are necessary for the county or city to qualify for state aid under the provisions of this article and article six of this chapter and the rules and regulations promulgated thereunder.

§ 2202. Tuberculosis; care and treatment. 1. (a) Notwithstanding any inconsistent provision of this chapter or of any other general, special or local law or city charter, when a person suffering from tuberculosis or suspected of having tuberculosis is in need of care and treatment therefor from a hospital, as defined in article twenty-eight of this chapter, or a certified home health agency which provides such care and treatment, the county or the city of New York, as the case may be, in which such person resides or is found shall provide or secure such care and treatment.

(b) The legislative body of each county and the corresponding authority of the city of New York shall designate the commissioner of health of any county or part-county health district or the city of New York or, in a county lacking a county or part-county health district, the county health director, or appropriate health officer, as the case may be, to be responsible for providing or securing such care and treatment.

(c) The cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment of such care and treatment shall be a charge against the county or the city of New York, as the case may be, in which such person has local residence, except that third party coverage or indemnification shall first be applied against the total cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment of the individual's care and treatment as hereinafter provided.

(d) The care and treatment of state charges, as defined in this article, shall be subject to the rules of the commissioner who may designate any local public official to act for him in emergency cases involving such state charges.

(e) Diagnoses, tests, studies or analyses for the discovery of tuberculosis and care and treatment by a hospital, as defined in article twenty-eight of this chapter, or by a certified home health agency which are provided by the state or by any county or city shall be available without cost or charge to the persons receiving such examinations, care or treatment, except that the third party coverage or indemnification shall first be applied against the total cost to the hospital or other

provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment of the individual's care and treatment as hereinafter provided.

2. Any person who volunteers to assume and pay for the cost of such hospital care and treatment or for the cost of such diagnosis, test, study or analysis shall be permitted to do so; but no state, county, city or other public official shall request or require payment or make, or cause to be made, any inquiry or investigation for the purpose of determining the ability of a person or of his legally responsible relatives to pay for diagnoses, tests, studies or analyses for the discovery of tuberculosis or for care and treatment provided by a hospital, as defined by article twenty-eight of this chapter, or by a certified home health agency except to determine if there is third party coverage or indemnification to pay or indemnify all or part of such cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment.

3. Determinations and orders concerning liability to pay for care and treatment and the provision of care and treatment to persons suffering from tuberculosis or suspected of having tuberculosis by the state or by any county or city shall be in accordance with the rules and regulations of the commissioner and expenses incurred therefor shall be eligible for state aid reimbursement pursuant to the provisions of title two of article six of this chapter after applying against the total cost to the hospital or other provider as established in accordance with the provisions of section twenty-eight hundred seven of this chapter relating to rates of payment of the individual's treatment the amounts received from or payable by medicare, workers' compensation, medical assistance in accordance with the social services law, or other third party payers and indemnitors and less any payments made or assignable under any federal law or laws heretofore enacted, provided, however, that expenses incurred for inpatient hospital care shall be eligible for reimbursement for a period not to exceed six weeks for any individual patient during any calendar year, unless approved as necessary by the commissioner for a longer period of time.

4. If upon a review of a claim submitted for the purposes of state aid reimbursement, the county, or the part county health district, or the city of New York, or the state determine that the person was in fact eligible for third party coverage or indemnification at the time care and treatment was provided and the hospital or certified home health agency failed to make a good faith effort to determine third party coverage or indemnification, the hospital or the certified home health agency shall not receive state aid reimbursement for that claim from the county or the city of New York. The commissioner shall promulgate rules and regulations requiring recoupment or repayment from the hospital or the certified home health agency if the hospital or the certified home health agency has already received state aid reimbursement from the county or the city of New York.

§ 2204. Tuberculosis; removal of patients to another state or country; costs. 1. When any state charge, as defined in this article, who has not acquired state residence has settlement or residence or otherwise belongs to or in any other state or country, has legally responsible relatives or friends willing to undertake the obligations to support him or to aid in supporting him in such other state or country, the department may furnish him with transportation to such state or country, provided, in the judgment of the commissioner the interest of the state and the welfare of such person will be promoted thereby.

2. The commissioner shall designate or employ nurses or attendants to accompany such persons being removed out of the state unless it appears that such persons are in suitable condition to travel alone with safety.

3. The expense of such removal shall be paid from the state treasury on the audit and warrant of the comptroller pursuant to a verified account submitted by the department, and the commissioner shall thereupon seek reimbursement for such expense from the state or country of residence.

§ 2205. Tuberculosis; removal of patients to this state; reciprocity agreements. 1. The commissioner may make reciprocal agreements with state officials or agencies of other states regarding interstate transportation of state charges without state residence and to arrange for the acceptance and tuberculosis hospital care and treatment of persons receiving similar public care and treatment in other states in accordance with the terms of such reciprocal agreements, but this state shall not, nor shall any county or city be committed to such care and treatment of persons who are not, in the opinion of the commissioner, entitled to such public care and treatment by the laws of this state.

2. No agreement made pursuant to the provisions of this section shall become effective until the attorney general has approved its form and sufficiency.

§ 2206. Tuberculosis; administration costs; appropriations. The appropriations made or to be made for the purposes of carrying out the provisions of this article and article six of this chapter providing for state aid for tuberculous patients shall be available, in accordance with certificates of approval issued or to be issued by the director of the budget, to the commissioner for the payment of expenses of personal service and other maintenance and operation, including purchase of equipment and the purchase of passenger automobiles and for travel outside the state, necessary for the administration of this article.

§ 2207. Tuberculosis; application of law to city of New York. All of the provisions of sections two thousand two hundred to two thousand two hundred seven, inclusive, of this chapter, shall apply throughout the entire state and to each county and city thereof, including the city of New York.

TITLE II

CONTROL

Section 2221. Tuberculosis; records of tuberculous patients;

confidential.

- 2222. Tuberculosis; protection of patient's family; duty of physicians and health officers.
- 2223. Tuberculosis; carelessness of patients; violation and penalty; duty of health officer.
- 2224. Tuberculosis; false reports; violation and penalty.
- 2225. Tuberculosis; recovery of patient; duty to report.
- 2226. Tuberculosis; death or removal of patient from premises; notice to health officer.
- 2227. Tuberculosis; duty of public health council.
- 2229. Tuberculosis; vaccine and vaccination.
- 2230. Tuberculosis; violations and penalties.

§ 2221. Tuberculosis; records of tuberculous patients; confidential.

Reports of tuberculous patients made pursuant to law and the sanitary code and also all records of examinations of such patients shall not be open to inspection by any person other than the health authorities of the state and of the local health district, and said health authorities shall not permit any such report or record to be divulged so as to disclose the identity of the person to whom it relates, except as may be authorized in the sanitary code.

§ 2222. Tuberculosis; protection of patient's family; duty of physicians and health officers. 1. It shall be the duty of a physician attending a patient having tuberculosis to take all proper precautions and to give proper instructions to provide for the safety of all individuals occupying the same house or apartment, and if no physician be attending such patient this duty shall devolve upon the state district health officer or local health officer.

2. All duties imposed upon physicians by any sections of this article shall be performed by the state district health officer or local health officer in all cases of tuberculosis not attended by a physician, or when the physician fails to perform the duties herein specified.

§ 2223. Tuberculosis; carelessness of patients; violation and penalty; duty of health officer. 1. Any person having tuberculosis who shall dispose of his sputum, saliva or other bodily secretion or excretion so as to cause offense or danger to any person or persons occupying the same room or apartment, house, or part of a house, shall on complaint of any person or persons subjected to such offense or danger, be deemed guilty of a nuisance and any persons subjected to such a nuisance may make complaint in person or writing to the health officer of the local health district where the nuisance complained of is committed.

2. It shall be the duty of the local health officer receiving such complaint to investigate and if it appears that the nuisance complained of is such as to cause offense or danger to any person occupying the same room, apartment, house or part of a house, he shall serve a notice upon the person so complained of, reciting the alleged cause of offense or danger and requiring him to dispose of his sputum, saliva or other bodily secretion or excretion in such a manner as to remove all reasonable cause of offense or danger.

3. Any person failing or refusing to comply with orders or regulations of the local health officer requiring him to cease to commit such nuisance, shall be deemed guilty of a misdemeanor and on conviction thereof shall be fined not more than ten dollars.

§ 2224. Tuberculosis; false reports; violation and penalty. Any physician or person practicing as a physician who shall wilfully make any false statement concerning the name, age, sex, color, occupation, place where last employed if known, or address of any person reported as affected with tuberculosis, or who shall certify falsely as to any of the precautions taken to prevent the spread of infection, shall be deemed guilty of a misdemeanor, and on conviction thereof shall be subject to a fine of not more than one hundred dollars.

§ 2225. Tuberculosis; recovery of patient; duty to report. Upon the

recovery of any person having tuberculosis, it shall be the duty of the attending physician to make a report of this fact to the proper health officer, who shall record the same in the records of his office, and shall relieve said person from further liability to any requirements imposed by this article.

§ 2226. Tuberculosis; death or removal of patient from premises; notice to health officer. In case of the vacation of any apartment or premises by the death or removal therefrom of a person having tuberculosis, it shall be the duty of the attending physician, or if there be no such physician, or if such physician be absent, of the owner, lessee, occupant, or other person having charge of the said apartment or premises, within twenty-four hours thereafter, to notify the health officer of the local health district of said death or removal.

§ 2227. Tuberculosis; duty of public health council. The public health council shall include in the sanitary code regulations defining the methods and precautions to be observed in disinfecting, cleansing, or renovating premises under the provisions of this article.

§ 2229. Tuberculosis; vaccine and vaccination. 1. No vaccine shall be used for the purpose of inducing immunity against tuberculosis in humans in this state unless produced in accordance with regulations established or approved by the commissioner.

2. Vaccination with such approved vaccine shall be performed only in accordance with regulations established by the commissioner.

§ 2230. Tuberculosis; violations and penalties. Any person violating any of the provisions of sections two thousand two hundred twenty to two thousand two hundred twenty-six, inclusive, of this chapter shall be deemed guilty of a misdemeanor and upon conviction thereof shall be

subject, except as in this article otherwise provided, to a fine of not less than five dollars nor more than fifty dollars.

ARTICLE 23

CONTROL OF SEXUALLY TRANSMITTED DISEASES

Title I. Care and treatment (§§ 2304-2312).

II. Houses of prostitution: injunction and abatement (§§ 2320-2334).

TITLE I

CARE AND TREATMENT

- Section 2304. Sexually transmitted diseases; treatment facilities; administration.
2305. Sexually transmitted diseases; treatment by licensed physician or staff physician of a hospital; prescriptions.
2306. Sexually transmitted diseases; reports and information, confidential.
2307. Venereal disease; person knowing himself to be infected.
2308. Sexually transmitted disease; pregnant women; blood test for syphilis.
- 2308-a. Sexually transmitted diseases; tests for sexually transmitted diseases.
2311. Sexually transmitted disease list.
2312. Expedited partner therapy for chlamydia trachomatis infection and other sexually transmitted infections.

§ 2304. Sexually transmitted diseases; treatment facilities; administration. 1. It shall be the responsibility of each board of health of a health district to provide adequate facilities for the diagnosis and treatment of persons living within its jurisdiction who are suspected of being infected or are infected with a sexually transmitted disease.

2. The health officer of said health district shall administer these facilities directly or through contract and shall promptly examine or arrange for the examination of persons suspected of being infected with a sexually transmitted disease, and shall promptly institute treatment or arrange for the treatment of those found or otherwise known to be infected with a sexually transmitted disease, provided that any person may, at his option, be treated at his own expense by a licensed physician of his choice.

3. The facilities provided by the board of health and the administration of these facilities by the health officer shall comply with requirements of the commissioner.

4. Each board of health and local health officer shall ensure that diagnosis and treatment services are available and, to the greatest extent practicable, seek third party coverage or indemnification for such services; provided, however, that no board of health, local health officer, or other municipal officer or entity shall request or require that such coverage or indemnification be utilized as a condition of providing diagnosis or treatment services.

5. The term "health officer" as used in this article shall mean a county health officer, a city health officer, a town health officer, a village health officer, the health officer of a consolidated health district or a state district health officer.

§ 2305. Sexually transmitted diseases; treatment by licensed physician or staff physician of a hospital; prescriptions. 1. No person, other than a licensed physician, or, in a hospital, a staff physician, shall diagnose, treat or prescribe for a person who is infected with a sexually transmitted disease, or who has been exposed to infection with a sexually transmitted disease, or dispense or sell a drug, medicine or remedy for the treatment of such person except on prescription of a duly licensed physician.

2. A licensed physician, or in a hospital, a staff physician, may

diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmitted disease, or has been exposed to infection with a sexually transmitted disease.

3. For the purposes of this section, the term "hospital" shall mean a hospital as defined in article twenty-eight of this chapter.

§ 2306. Sexually transmitted diseases; reports and information, confidential. All reports or information secured by a board of health or health officer under the provisions of this article shall be confidential except in so far as is necessary to carry out the purposes of this article. Such report or information may be disclosed by court order in a criminal proceeding in which it is otherwise admissible or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the prosecution and to the defense, or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the petitioner, respondent and attorney for the child, provided that the subject of the report or information has waived the confidentiality provided for by this section except insofar as is necessary to carry out the purposes of this article. Information may be disclosed to third party reimbursers or their agents to the extent necessary to reimburse health care providers for health services; provided that, when necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider. A person waives the confidentiality provided for by this section if such person voluntarily discloses or consents to disclosure of such report or information or a portion thereof. If such person lacks the capacity to consent to such a waiver, his or her parent, guardian or attorney may so consent. An order directing disclosure pursuant to this section shall specify that no report or information shall be disclosed pursuant to such order which identifies or relates to any person other than the subject of the report or information. Reports and information may be used in the aggregate in programs approved by the commissioner for the improvement of the quality of medical care provided to persons with

sexually transmitted diseases; or with patient identifiers when used within the state or local health department by public health disease programs to assess co-morbidity or completeness of reporting and to direct program needs, in which case patient identifiers shall not be disclosed outside the state or local health department except as otherwise provided for in this section.

§ 2307. Venereal disease; person knowing himself to be infected. Any person who, knowing himself or herself to be infected with an infectious venereal disease, has sexual intercourse with another shall be guilty of a misdemeanor.

§ 2308. Sexually transmitted disease; pregnant persons; blood test for syphilis. 1. Every physician or other authorized practitioner attending pregnant persons in the state shall in the case of every person so attended take or cause to be taken a sample of blood of such person at the time of first examination, and submit such sample to an approved laboratory for a standard serological test for syphilis. In addition to testing at the time of first examination, every such physician or other authorized practitioner shall order a syphilis test during the third trimester of pregnancy consistent with any guidance and regulations issued by the commissioner.

2. Every other person permitted by law to attend upon pregnant women in the state but not permitted by law to take blood tests, shall cause a sample of the blood of such pregnant woman to be taken promptly by a duly licensed physician and submitted to an approved laboratory for a standard serological test for syphilis.

3. The term "approved laboratory" means a laboratory approved for the purpose as herein provided by the department, or in the city of New York by the department of health of such city.

4. A standard serological test for syphilis is one recognized as such by the department or in the city of New York by the department of health

of such city.

§ 2308-a. Sexually transmitted diseases; tests for sexually transmitted diseases. 1. The administrative officer or other person in charge of a clinic or other facility providing gynecological, obstetrical, genito-urological, contraceptive, sterilization or termination of pregnancy services or treatment shall require the staff of such clinic or facility to offer to administer to every resident of the state of New York coming to such clinic or facility for such services or treatment, appropriate examinations or tests for the detection of sexually transmitted diseases.

2. Each physician providing gynecological, obstetrical, genito-urological, contraceptive, sterilization, or termination of pregnancy services or treatment shall offer to administer to every resident of the state of New York coming to such physician for such services or treatment, appropriate examinations or tests for the detection of sexually transmitted diseases.

§ 2311. Sexually transmitted disease list. The commissioner shall promulgate a list of sexually transmitted diseases, such as gonorrhea and syphilis, for the purposes of this article. The commissioner, in determining the diseases to be included in such list, shall consider those conditions principally transmitted by sexual contact, other sections of this chapter addressing communicable diseases and the impact of particular diseases on individual morbidity and the health of newborns.

§ 2312. Expedited partner therapy for chlamydia trachomatis infection and other sexually transmitted infections. 1. Notwithstanding any other provision of law and consistent with section two thousand three hundred five of this title, a health care practitioner (who is authorized under title eight of the education law to diagnose and prescribe drugs for sexually transmitted chlamydia trachomatis infection and other sexually

transmitted infections, acting within his or her lawful scope of practice) who diagnoses a sexually transmitted chlamydia trachomatis infection or other sexually transmitted infection in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs for the sexually transmitted infections for which the Centers for Disease Control and Prevention recommends the use of expedited partner therapy to that patient's sexual partner or partners without examination of that patient's partner or partners.

2. A health care practitioner who reasonably and in good faith renders expedited partner therapy in accordance with this section and following the rules and regulations promulgated by the commissioner shall not be subject to civil or criminal liability or be deemed to have engaged in unprofessional conduct.

3. The commissioner shall promulgate rules and regulations concerning the implementation of this section and shall also develop forms for patients and their partners explaining expedited partner therapy for a chlamydia trachomatis infection and other sexually transmitted infections for which the Centers for Disease Control and Prevention recommends the use of expedited partner therapy. Such forms shall be written in a clear and coherent manner using words with common, everyday meanings.

TITLE II

HOUSES OF PROSTITUTION: INJUNCTION AND ABATEMENT

- Section 2320. Houses of prostitution; equipment; nuisance.
2321. Houses of prostitution; injunction; jurisdiction, complaint and parties to the action.
2322. Houses of prostitution; injunction; service of summons.
2323. Houses of prostitution; injunction; temporary restraining order; service.
2324. Houses of prostitution; injunction; trial of action.
- 2324-a. Presumptive evidence.
2325. Houses of prostitution; injunction; withdrawal of complaint.

- 2326. Houses of prostitution; injunction; dismissal; costs against plaintiff.
- 2327. Houses of prostitution; injunction; scope; violation.
- 2328. Houses of prostitution; injunction; penalty for violation.
- 2329. Houses of prostitution; injunction; order of abatement; sale and removal of property; fees.
- 2330. Houses of prostitution; abatement; breaking, entering or using closed building.
- 2331. Houses of prostitution; abatement; proceeds.
- 2332. Houses of prostitution; abatement; release of property on filing bond.
- 2333. Houses of prostitution; injunction proceedings; witnesses and officers fees.
- 2334. Houses of prostitution; criminal proceeding; duty of district attorney.

§ 2320. Houses of prostitution; equipment; nuisance. 1. Whoever shall erect, establish, continue, maintain, use, own, or lease any building, erection, or place used for the purpose of lewdness, assignation, or prostitution is guilty of maintaining a nuisance.

2. The building, erection, or place, or the ground itself, in or upon which any lewdness, assignation, or prostitution is conducted, permitted, or carried on, continued, or exists, and the furniture, fixtures, musical instruments, and movable property used in conducting or maintaining such nuisance, are hereby declared to be a nuisance and shall be enjoined and abated as hereafter provided.

§ 2321. Houses of prostitution; injunction; jurisdiction, complaint and parties to the action. 1. When a nuisance is kept, maintained, or exists, as defined in this article, the district attorney, or any citizen of the county, or any society, association, or body incorporated under the laws of this state, may maintain an action in equity in the name of the people of the state of New York, upon the relation of such

district attorney, citizen, or corporation to perpetually enjoin said nuisance, the person or persons conducting or maintaining the same from further conducting or maintaining the same, and the owner, or agent of the building or ground upon which said nuisance exists, from further permitting such building or ground or both to be so used.

2. Such action shall be brought in the supreme court of the county in which the property is situated.

3. The complaint in such action shall be verified and shall set forth the facts constituting the nuisance complained of, and may at or before the commencement of the action be filed in the office of the clerk of the county, together with a notice of the pendency of the action, stating the names of the parties and the object of the action, and containing a brief description of the property, real and personal, in the county affected thereby.

4. Upon the verified complaint and upon such other proof as the court may require, and notwithstanding any other provision of law to the contrary, the supreme court, or a justice of the supreme court, may, without a hearing and without notice, grant an injunction order, restraining the defendants and each of them from continuing such nuisance, and from removing, or in any manner interfering with, the furniture, fixtures, musical instruments and movable property used in conducting such nuisance, and described and set forth in the complaint, and in such order fix a time of hearing at a term of the supreme court to be held in such county, for an order continuing such injunction order during the pendency of the action.

5. Such injunction order shall be served, together with a copy of the complaint and the affidavits, if any, upon which the same was granted, personally upon the defendants, or by leaving copies thereof with a person of full age, if any such person be found at the premises described in the complaint, or by posting at or on the main entrance to the building on such premises, copies thereof, on or before the time fixed for such service in such injunction order. The defendants, or any of them, may upon such hearing submit proof by affidavits, and the

plaintiff may submit additional proof by affidavits. If it appears upon such hearing that there is probable proof of the maintenance of such nuisance, the court may continue the injunction order during the pendency of the action.

6. No bond or undertaking shall be required as a condition of granting or continuing such injunction order, or orders.

7. The person in whose name the real estate affected by the action is recorded in the county clerk's office shall be presumed to be the owner thereof.

8. The owner and any person having any claim or lien against the real or personal property affected by the action shall be made parties defendant. If any such persons be unknown to the relator such unknown persons shall be designated as "all other persons unknown claiming any ownership, right, title, or interest in the property affected by this action."

§ 2322. Houses of prostitution; injunction; service of summons. The summons in an action provided by section two thousand three hundred twenty-one of this chapter, may be served as in a civil action except that, in case service by publication is ordered, the mailing of a copy of the order and the summons to the defendant may be dispensed within the order and the order may provide that such publication in a paper published daily in the city where the property affected by the action is located, twice a week for two weeks, will be sufficient publication, in which case service will be deemed completed upon the date of last publication; and except that where personal service is made without the state, the service will be deemed completed upon the date of such personal service.

§ 2323. Houses of prostitution; injunction; temporary restraining order; service. 1. Where a permanent or temporary injunction is prayed for, the court, or judge in vacation, on the application of the

plaintiff, may issue an ex parte restraining order, restraining the defendants and all other persons from removing or in any manner interfering with the furniture, fixtures, musical instruments and movable property used in conducting the alleged nuisance, until the decision of the court or judge granting or refusing such temporary injunction and until the further order of the court thereon.

2. The restraining order may be served by handing to and leaving a copy of said order with any person in charge of said property or residing in the premises, and by posting a copy thereof in a conspicuous place at or upon one or more of the principal doors at entrances of such premises where such nuisance is alleged to be maintained, or by either such delivery or posting.

3. The officers serving such restraining order shall forthwith make and return into court an inventory of the personal property situated in and used in conducting or maintaining said nuisance and shall enter upon the premises for such purpose.

4. Where such order is so posted, mutilation or removal thereof, while the same remains in force, shall be a contempt of court, provided such posted order contains thereon or therein a notice to that effect.

§ 2324. Houses of prostitution; injunction; trial of action. 1. The action for a permanent injunction instituted pursuant to this article, shall be triable at the first term of the supreme court after due and timely notice has been served as in other actions.

2. If the complaint be uncontroverted it shall be deemed true without further proof.

3. (a) In such action evidence of the common fame and general reputation of the place, of the inmates or occupants thereof, or of those resorting thereto, shall be competent evidence to prove the existence of the nuisance.

(b) An admission or finding of guilt of any person of a violation of

section 230.40 of the penal law at such place shall be presumptive evidence of the nuisance, and a plea of guilty or a conviction in a criminal action of maintaining a nuisance at the place described in the complaint shall be prima facie evidence of the nuisance, and the records of any court in the jurisdiction shall be admissible as evidence to prove the conviction or plea of guilty.

(c) If evidence of the general reputation of the place, or of the inmates or occupants thereof, is sufficient to establish the existence of a nuisance it shall be prima facie evidence of knowledge thereof and acquiescence and participation therein and responsibility for the nuisance, on the part of the owners, lessors, lessees, users, and all those in possession of or having charge of, as agent or otherwise, or having any interest in any form of property, real or personal, used in conducting or maintaining said nuisance.

§ 2324-a. Presumptive evidence. For the purposes of this title, two or more convictions of any person or persons had, within a period of one year, for any of the offenses described in section 230.00, 230.05, 230.06, 230.08, 230.11, 230.12, 230.13, 230.20, 230.25, 230.30, 230.32 or 230.34-a of the penal law arising out of conduct engaged in at the same real property consisting of a dwelling as that term is defined in subdivision four of section four of the multiple dwelling law shall be presumptive evidence of conduct constituting use of the premises for purposes of prostitution.

§ 2325. Houses of prostitution; injunction; withdrawal of complaint.
1. If the complaint in an action instituted pursuant to the provisions of this article, is filed by any person or association, it shall not be dismissed except upon a sworn statement made by the complainant and his attorney, setting forth the reasons why the action should be dismissed, and the dismissal approved by the district attorney in writing or in open court.

2. If the judge is of the opinion that the action should not be dismissed, he may direct the district attorney to prosecute said action

to judgment, and if the action is continued more than one term of court, except for good cause shown, any citizen of the county or the district attorney may be substituted for the complaining party and prosecute said action to judgment.

§ 2326. Houses of prostitution; injunction; dismissal; costs against plaintiff. If an action instituted pursuant to the provisions of this article, is brought by any person or association and the court finds there were not reasonable grounds or cause for said action the costs may be taxed against such person or association.

§ 2327. Houses of prostitution; injunction; scope; violation. 1. When an injunction has been granted pursuant to the provisions of this article, it shall be binding on each defendant throughout the state, and any violation of the provisions of the injunction or temporary restraining order herein provided, shall be a contempt and punished as hereinafter provided.

2. In case of a violation of any injunction granted under the provisions of this article, or of a restraining order or the commission of any contempt of court in proceedings under this article the court, or in vacation a judge thereof, may summarily try and punish the offender.

3. The contempt proceedings shall be commenced by filing with the clerk of the court a complaint under oath, setting out and alleging the facts constituting such violation, upon which the court or judge shall cause a warrant to issue, under which the defendant shall be arrested. The trial may be had upon affidavits, or either party may demand the production and oral examination of the witnesses.

§ 2328. Houses of prostitution; injunction; penalty for violation. A party found guilty of contempt under the provisions of this article shall be punished by a fine of not less than three hundred nor more than one thousand dollars or by imprisonment for not less than three nor more

than six months or by both fine and imprisonment, for the first offense, and for the second and each subsequent offense shall be imprisoned for one year.

§ 2329. Houses of prostitution; injunction; order of abatement; sale and removal of property; fees. 1. If the existence of the nuisance be admitted or established in an action as provided in this article, or in a criminal proceeding in any court, an order of abatement shall be entered as a part of the judgment in the case, which order shall direct the removal from the building or place of all fixtures, furniture, musical instruments, or movable property used in conducting the nuisance and shall direct the sale of such in the manner provided for the sale of chattels under execution, and shall direct the effectual closing of the building, erection or place against its use for any purpose, and so keeping it closed for a period of one year, unless sooner released as hereinafter provided. Such closing, however, shall not be deemed, in any manner or form, to be an assumption of the supervision and care of the building, erection or place by any officer authorized to act pursuant to this section, if provision is made in the order of abatement that the owner or lessor of the building, erection or place shall be permitted access to supervise and maintain the building, erection or place. In cities having a population of one million or more, the order of abatement which shall be entered pursuant to this section may, in addition to or in lieu of the provisions set forth in this subdivision, direct the commissioner of the department of buildings of such city, or such other competent city official as may be appropriate, to issue an order to vacate for the purpose of assisting in the effectual closing of the building pursuant to this section. The issuance of such order to vacate and the closing of the building, erection or place in accordance therewith shall not be deemed, in any manner or form, an assumption of the supervision and care of the building, erection or place by any city authorized to act pursuant to this subdivision, if provision is made in the order of abatement that the owner or lessor of the building, erection or place shall be permitted access to supervise and maintain the building, erection or place.

2. For removing and selling the movable property, the officer shall be entitled to a charge and receive the same fees as he would for levying upon and selling like property, on execution and for closing the premises and keeping it closed a reasonable sum shall be allowed by the court.

§ 2330. Houses of prostitution; abatement; breaking, entering or using closed building. If any person shall break and enter, or use a building, erection, or place directed to be closed pursuant to the provisions of this article, he shall be punished as for contempt as provided in this article.

§ 2331. Houses of prostitution; abatement; proceeds. 1. All moneys collected under the provisions of sections two thousand three hundred twenty to two thousand three hundred thirty-four, inclusive, of this chapter, shall be paid to the county treasurer.

2. The proceeds of the sale of the personal property as provided in section two thousand three hundred twenty-nine of this chapter, shall be applied in payment of the costs of the action and abatement or so much of such proceeds as may be necessary, except as hereinafter provided.

§ 2332. Houses of prostitution; abatement; release of property on filing bond. 1. If the owner of the premises in which a nuisance, as defined in this article, has been maintained appears and pays all costs of the proceeding and files a bond with sureties to be approved by the court in the full value of the property, to be ascertained by the court, or in vacation by the judge thereof, conditioned that he will immediately abate said nuisance and prevent the same from being established, or kept therein within a period of one year thereafter, the court, or in vacation the judge, if satisfied of his good faith, may order the premises, closed or sought to be closed under the order of abatement, delivered to said owner, and said order of abatement cancelled so far as the same may relate to said real property.

2. The release of the property under the provisions of this section shall not release it from the injunction herein provided against the property nor any of the defendants nor from any judgment, lien, or liability to which it may be subject by law.

§ 2333. Houses of prostitution; injunction proceedings; witnesses and officers fees. In any action brought to enjoin and abate a nuisance, as defined in this article, no officer or witness shall be entitled to receive in advance fees for service or attendance.

§ 2334. Houses of prostitution; criminal proceedings; duty of district attorney. 1. In case the existence of a nuisance as defined in this article, is established, in a criminal action in a court other than the supreme court it shall be the duty of the district attorney to proceed promptly under the provisions of this article to enforce the provisions and penalties thereof.

2. The conviction of the defendant in such criminal action, unless reversed or set aside, shall be conclusive as against such defendant as to the existence of the nuisance.

ARTICLE 24

CONTROL OF MALIGNANT DISEASES

Title I. General provisions (§§ 2400--2404-d).
 I-A. Cancer Detection and Education Program (§§ 2405--2409-a).
 I-B. Health Research Science Board (§§ 2410-2413).
 II. State institute for the study of malignant diseases
 (§§ 2420-2423).

TITLE I

GENERAL PROVISIONS

Section 2400. Cancer; powers and duties of commissioner.

- 2401. Cancer; duty to report.
- 2401-a. Skin cancer reporting.
- 2401-b. Cancer incidence and environmental facility maps.
- 2402. Cancer; reports confidential.
- 2403. Cancer; compulsory submission for supervision or inspection not required.
- 2404. Breast cancer; duty to inform.
- 2404-a. Prostate cancer; duty to inform.
- 2404-b. Breast cancer; duty of providers of mammography services to ascertain and provide clinical breast examination information.
- 2404-c. Breast cancer; duty of providers of mammography services to notify and inform.
- 2404-d. Breast cancer; duty to provide extended hours.

§ 2400. Cancer; powers and duties of commissioner. The commissioner shall conduct investigations of the cause, mortality, methods of treatment, prevention and cure of cancer, and allied diseases, including the nature and extent of the facilities available in the several counties and cities of the state, for the diagnosis and treatment of these diseases, and shall cooperate with local health authorities, physicians, hospitals, clinics and voluntary associations, in the development of suitable facilities for the diagnosis, treatment and control of cancer.

§ 2401. Cancer; duty to report. 1. Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided.

2. Whenever an examination of a tissue specimen in a laboratory discloses the existence of cancer or other malignant disease, the person in charge of such laboratory or the person making such examination shall immediately but not later than one hundred eighty days report the same

together with all the facts in connection therewith to the department.

3. The person in charge of every cancer reporting facility shall immediately but not later than one hundred eighty days give notice of every case of cancer or malignant disease coming under the care of the institution to the department.

4. All abstracting work performed by a cancer reporting facility pursuant to the reporting provisions of this section shall be performed by a certified tumor registrar. Cancer reporting facilities may establish consortia to engage a certified tumor registrar to perform the reporting requirements of this section. A "certified tumor registrar" is an individual certified by a nationally recognized not-for-profit organization which certifies tumor registrars. The provisions of this subdivision shall not apply to any cancer reporting facility which renders services for one hundred or fewer cases of cancer and malignant disease per year as determined by the commissioner.

5. The department shall establish and update as necessary a manual designating which specific data elements shall be reported to the department pursuant to this section. The department shall make such manual available to every cancer reporting facility, physician, dentist and other health care provider required to comply with the provisions of this section.

6. The department shall establish and update as necessary a data dictionary to standardize information interpretation of data elements reported by cancer reporting facilities and other health care providers. The department shall make such dictionary available to every cancer reporting facility, physician, dentist and other health care provider required to comply with the provisions of this section.

7. The department shall, to the extent funds are made available, establish or contract for regional training programs to provide training to any cancer reporting facility, physician, dentist or other health care provider required to comply with the provisions of this section. Such regional training programs shall provide training relating to the

specific data elements which must be reported pursuant to this section, the data dictionary established pursuant to this section, and any other subjects which are intended to ensure quality, timely and complete compliance with this section.

8. The department shall, meet cancer registry goals established by a nationally recognized central cancer registry organization unless any such goal is contrary to any provision of law.

9. Where a cancer reporting facility fails to comply with the provisions of this section, the department may elect to perform registry services for such facility. Such cancer reporting facility shall reimburse the department for actual expenses incurred.

10. A physician, dentist, laboratory, cancer reporting facility or other health care provider which violates any provision of this section shall be subject to a civil penalty as provided in section twelve of this chapter.

11. The notices required by this section shall be upon forms supplied by the commissioner and shall contain such information as shall be required by the commissioner.

12. For the purpose of this section, a "cancer reporting facility" means a hospital as defined in article twenty-eight of this chapter, clinic or any organization certified pursuant to article forty-four of this chapter, or other similar public or private institution.

13. The commissioner shall have the power to promulgate any such rules and regulations as shall be necessary and proper to effectuate the purposes of this section.

§ 2401-a. Skin cancer reporting. The department shall submit a written report every three years, commencing January first, two thousand eighteen, to the governor and the legislature on the incidence of skin cancer in the state of New York, by type and as a percentage of the

overall number of reported cases of all types of cancer, as well as the associated causes of each type of skin cancer, if such causes are readily ascertainable. Such report shall be generated based on data gathered and reviewed pursuant to this title, and shall provide information which is as current as practicable; provided, however, a retrospective of the past ten years of information collected pursuant to this title and predominant trends associated with such information, as concerns skin cancer and its associated causes, shall be a component of such report and each report submitted thereafter. At the discretion of the commissioner, such reports may provide additional information other than the information required by this section. The first report created pursuant to this section shall be submitted one year after the effective date of this section. The reports generated pursuant to this section shall be made available to the public on the department's website.

*** § 2401-b. Cancer incidence and environmental facility maps.** 1. For purposes of this section, "environmental facility" shall have the same meaning as provided in section 3-0317 of the environmental conservation law.

2. For purposes of this section, "cancer incidence and environmental facility maps technical advisory group" or "technical advisory group" shall mean the environmental public health tracking program technical advisory group required by a cooperative agreement between the department and the federal centers for disease control and prevention.

3. The technical advisory group shall make recommendations to the department on the appropriate use and communication of the cancer incidence and environmental facility maps. Such recommendations shall consider the scientific strengths and limitations of such mapping and overlay methodologies for cancer tracking and geospatial linking to significant disease risk factors, and the appropriate means for communicating such strengths and limitation to the public in an easily discernible manner. The department shall consider the recommendations of the technical advisory group when making the maps required by this section available to the public.

4. The department, in consultation with the department of environmental conservation and the technical advisory group, shall establish and maintain a computer mapping system for plotting cancer incidence and environmental facilities throughout the state, including but not limited to cancer clusters. Such maps shall overlay locations of environmental facilities with cancer incidences.

5. Cancer incidence and environmental facility maps shall include data on the incidence of the following cancer types:

- (a) lung and bronchus;
- (b) female breast;
- (c) urinary bladder (including in situ);
- (d) brain and other nervous system;
- (e) colon and rectum;
- (f) non-Hodgkin lymphomas;
- (g) leukemias;
- (h) thyroid;
- (i) liver/intrahepatic bile duct;
- (j) kidney and renal pelvis;
- (k) prostate;
- (l) oral cavity and pharynx;
- (m) stomach;
- (n) esophagus;
- (o) larynx;
- (p) pancreas;
- (q) corpus uterus;
- (r) ovary;
- (s) testis;
- (t) mesothelioma;
- (u) bone;
- (v) nasal and nasopharynx; and
- (w) soft tissue sarcomas.

6. Plotting of data for cancer incidence and environmental facility maps shall be by census block, except in cases where such plotting could disclose the identity of any person to whom the data relate, in which

case census blocks shall be aggregated for plotting to protect the identity of such person. When such aggregation is required, the department shall utilize the minimum number of census blocks practicable to protect the identity of such person.

7. By March first, two thousand eleven the department shall make available to the public information on cancer as designated by the environmental public health tracking program of the centers for disease control and prevention, and, in consultation with the department of environmental conservation, current data on locations and type of environmental facilities.

8. By June thirtieth, two thousand eleven the department shall make available to the public cancer incidence and environmental facility maps which show available information on the location of environmental facilities and the total number of reported cancers by census block and associated data for each reported cancer type listed in subdivision five of this section.

9. The department shall make available to the public cancer incidence and environmental facility maps in the manner described in subdivision four of this section showing cancer clusters by cancer types. Prior to plotting such data, the department shall use an appropriate statistical method to detect statistical anomalies for the purpose of identifying cancer clusters.

The department shall make such maps available on its public website, and shall, in consultation with the department of environmental conservation, update the maps not less than once every five years.

* NB Repealed May 1, 2028

§ 2402. Cancer; reports confidential. The reports of cancer cases made pursuant to the provisions of this article shall not be divulged or made public so as to disclose the identity of any person to whom they relate, by any person, except in so far as may be authorized in the sanitary code.

§ 2403. Cancer; compulsory submission for supervision or inspection not required. Nothing in this article shall be construed to compel any individual to submit to medical or health department supervision or inspection.

§ 2404. Breast cancer; duty to inform. 1. The commissioner shall develop a standardized written summary, in plain non-technical language, which shall explain the alternative medically viable methods of treating breast cancer, including but not limited to hormonal, radiological, chemotherapeutic or surgical treatments, or combinations thereof. The summary shall contain information on breast or chest wall reconstructive surgery, including but not limited to, the use of breast implants, their side effects, risks and other pertinent information to aid a person in deciding on a course of treatment. Chest wall reconstructive information shall include information on aesthetic flat closure as such term is defined by the National Cancer Institute.

1-a. The informational summary shall also include an explanation of the special provisions relating to mastectomy, lymph node dissection, or lumpectomy, and breast or chest wall reconstructive surgery coverage, and second opinion coverage (including out-of-network options) under the insurance law and section twenty-eight hundred three-o of this chapter, and suggest that patients undergoing such procedures check their health plans and/or insurance policies for the details of their coverage.

2. The standardized written summary for alternative breast cancer treatments shall be provided by a physician to each person under his care who has been diagnosed to be afflicted with breast cancer upon said diagnosis, or as soon thereafter as practicable.

3. The summary shall be updated as is necessary.

4. Nothing in this section shall be construed to create a cause of action for lack of informed consent in any instance in which such cause

of action would be limited by section twenty-eight hundred five-d of this chapter.

§ 2404-a. Prostate cancer; duty to inform. 1. The commissioner shall develop a standardized written summary, in plain non-technical language, which shall explain the following:

(a) the symptoms and risk factors for prostate cancer;

(b) the available methods for the detection and diagnosis of prostate cancer, including information on the relative accuracy of the available detection and diagnostic techniques;

(c) the availability of insurance coverage for diagnostic screening for prostate cancer without cost sharing pursuant to subparagraph (B) of paragraph eleven-a of subsection (i) of section three thousand two hundred sixteen, subparagraph (B) of paragraph eleven-a of subsection (1) of section three thousand two hundred twenty-one and paragraph two of subsection (z-1) of section four thousand three hundred three of the insurance law; and

(d) the alternative medically viable methods of treating prostate cancer, including but not limited to hormonal, radiological, chemotherapeutic or surgical treatments, or combinations thereof. The summary shall contain information on prostate post-treatment risks and other pertinent information to aid a person in deciding a course of treatment. The summary shall be updated as is necessary.

2. The summary shall be provided to any health care provider or practitioner providing medical treatment to adult men without charge or fee for distribution in accordance with subdivision three of this section.

3. The standardized written summary provided for by subdivision one of this section may be provided by a health care provider to each person under his or her care who is or may be at risk for prostate cancer or who has been diagnosed to be afflicted with prostate cancer upon said diagnosis, or as soon thereafter as practicable.

4. Nothing in this section shall be construed to create a cause of

action for lack of informed consent in any instance in which such cause of action would be limited by section twenty-eight hundred five-d of this chapter.

5. The commissioner shall have the written summary, required by this section, completed and prepared for distribution on or before January first, nineteen hundred ninety-eight.

§ 2404-b. Breast cancer; duty of providers of mammography services to ascertain and provide clinical breast examination information. Every provider who provides mammography services shall ascertain when, or if, their patients have had a clinical breast examination prior to providing such service and shall include such information with any mammography results or reports to alert healthcare providers if a clinical breast examination has not recently been performed. Criminal penalties for violation pursuant to subdivisions one and two of section twelve-b of this chapter shall not apply to this section.

§ 2404-c. Breast cancer; duty of providers of mammography services to notify and inform. Every provider of mammography services shall, if a patient's mammogram demonstrates dense breast tissue, provide notification to such patient that shall include, but not be limited to, the following information, in any summary of the mammography report sent, pursuant to the federal mammography quality standards act, to the patient:

Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with an increased risk of breast cancer.

This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your

results was sent to your physician.

For the purposes of this section dense breast tissue shall mean heterogeneously dense or extremely dense tissue as defined in nationally recognized guidelines or systems for breast imaging reporting of mammography screening, including, but not limited to, the breast imaging reporting and data system of the American College of Radiology, and any equivalent new terms, as such guidelines or systems are updated.

§ 2404-d. Breast cancer; duty to provide extended hours. 1.

Applicability. This section shall apply to any general hospital or extension clinic that is certified as a mammography facility pursuant to the federal mammography quality standards act (MQSA).

2. Extended service hours. Any general hospital or extension clinic certified as a mammography facility pursuant to the MQSA shall provide extended hours, i.e. in the early morning, evening, or weekend hours, for screening mammography services. Extended hours for screening mammography services shall be provided on at least two days each week, for at least two hours each day offered, for a total of at least four hours each week, including but not limited to the following times:

(a) Monday through Friday, between the hours of 7:00 AM and 9:00 AM;

(b) Monday through Friday, between the hours of 5:00 PM and 7:00 PM;

or

(c) Saturday or Sunday, between the hours of 9:00 AM and 5:00 PM.

3. Waiver. (a) A facility may submit an application for a waiver from the requirements of this section, in whole or in part, if it can demonstrate, to the department's satisfaction, that the facility:

(i) does not have sufficient staff to provide extended hours for screening mammography services in accordance with this section, and that it is making diligent efforts to obtain staffing such that it can provide extended hours;

(ii) is in the process of discontinuing screening mammography services, as part of a consolidation or similar change; or

(iii) is subject to such other hardships as the department deems

appropriate.

(b) The department may deny, grant or extend a waiver pursuant to paragraph (a) of this subdivision for ninety days, or more if the department determines appropriate, in its sole discretion.

TITLE I-A

CANCER DETECTION AND EDUCATION PROGRAM

Section 2405. Cancer detection and education program; establishment.

2406. Grants to approved organizations.

2406-a. Grants to community-based organizations.

2408. Annual report.

2409. Ovarian cancer information program.

2409-a. Advisory council.

§ 2405. Cancer detection and education program; establishment. 1.

There is hereby created within the department the cancer detection and education program, also known as the cancer services program. This program is established to promote screening and detection of cancer among unserved or underserved populations, to educate the public regarding cancer and the benefits of early detection, and to provide counseling and referral services. For purposes of this section, "unserved or underserved populations" shall mean persons having inadequate access and financial resources to obtain cancer screening and detection services, including persons who lack health insurance or whose health insurance coverage is inadequate or who cannot meet their deductible obligations for purposes of accessing coverage under their health insurance.

2. The program shall include:

(a) establishment of a statewide public education and outreach campaign to publicize evidence based cancer detection and education services, such campaign shall include: general community education, outreach to specific underserved populations, evidence based clinical cancer screening services, and an informational summary that shall include an explanation of the importance of clinical examinations and

what to expect during clinical examinations and cancer screening services;

(b) provision of grants to approved organizations under section twenty-four hundred six of this title;

(c) compilation of data concerning the cancer detection and education program and dissemination of the data to the public; and

(d) development of professional education programs including the benefits of early detection of cancer and clinical examinations, the recommended frequency of clinical examinations and cancer screening services, and professionally recognized best practices guidelines.

§ 2406. Grants to approved organizations. 1. The commissioner shall make grants within the amounts appropriated to approved organizations for the provision of services relating to the evidence based screening and detection of cancer as part of this program. Such services shall include but not be limited to:

(a) promotion and provision of early detection of cancer, including clinical examinations and cancer screening services;

(b) provision of counseling and information on treatment options and referral for appropriate medical treatment;

(c) dissemination of information to unserved and underserved populations, to the general public and to health care professionals concerning cancer, the benefits of early detection and treatment, and the availability of cancer screening services;

(d) identification of local cancer screening services within the approved organization's region;

(e) provision of information, counseling and referral services to individuals diagnosed with cancer; and

(f) provision of information regarding the availability of medical assistance, including medical assistance under paragraph (v) of subdivision four of section three hundred sixty-six of the social services law, to an individual who requires treatment for cancer.

2. The commissioner shall give notice and provide opportunity to submit applications to provide cancer detection and education programs. In order to be considered for a grant to provide cancer detection and

education programs, applicants must show evidence of the following:

- (a) ability to provide and to ensure consistent and quality cancer detection services;
- (b) expertise in cancer detection and treatment;
- (c) capacity to coordinate services with physicians, hospitals and other appropriate local institutions or agencies;
- (d) ability to provide cancer detection and education services to unserved or underserved populations; and
- (e) ability to implement a cancer detection and education program in accordance with the standards specified in subdivision three of this section.

Applications shall be made on forms provided by the commissioner.

3. The commissioner shall develop standards for the implementation of cancer detection and education programs by approved organizations which shall ensure the following:

- (a) integration of the approved organization with existing health care providers;
- (b) maximizing third party reimbursement;
- (c) provision of services to unserved or underserved populations.

4. Within the amounts of state or federal funds appropriated for cancer early detection and diagnosis, approved organizations may be authorized by the department to provide such services for populations served pursuant to this title. Early detection services shall include, but not be limited to, complete examinations, evidence based screening, patient education, counseling, follow-up and referral.

§ 2406-a. Grants to community-based organizations. 1. The commissioner shall make grants within any such amount as may be appropriated specifically for community-based organizations for the provision of counseling, education and outreach programs for persons diagnosed with breast cancer.

2. For the purposes of this section, "community-based organizations"

shall mean grass roots, free-standing organizations in which breast cancer survivors hold significant decision-making responsibility, and which offer a broad range of breast cancer education and support services free of charge.

3. The commissioner shall provide notice and opportunity for community-based organizations to submit applications to provide post-diagnosis breast cancer counseling, education and outreach programs. Such applications shall be on forms established by the commissioner.

§ 2408. Annual report. The commissioner shall submit on or before December first, an annual report to the governor and the legislature concerning the operation of the breast and cervical cancer detection and education program. Commencing in nineteen hundred ninety-five, such reports shall include the experience of the program in providing cervical cancer early detection and diagnostic services. The annual report shall include strategies for implementation of the cervical cancer prevention plan and for promoting the plan to the general public, state and local elected officials, and various public and private organizations, associations, businesses, industries, and agencies. Approved organizations shall provide such data and assessment as the commissioner may require for such report. Such report shall also include any recommendations for additional action to respond to the high incidence of breast cancer in this state.

§ 2409. Ovarian cancer information program. 1. There is hereby created within the department the ovarian cancer information program (referred to in this section as the "program"), which shall provide information for consumers, patients, and health care providers relating to ovarian cancer, including signs and symptoms, risk factors, the benefits of early detection through appropriate diagnostic testing and treatment options.

2. The program may include but not be limited to the following

elements:

- (a) educational and informational materials in print, audio, video, electronic, or other media;
- (b) public service announcements and advertisements; and
- (c) establishment of toll-free telephone hotlines to provide information.

3. The department shall produce, make available to others for reproduction, or contract with others to develop the materials mentioned in this section as the commissioner deems appropriate. These materials shall be made available to the public free of charge as appropriate or for a fee under certain circumstances. The commissioner shall require, where appropriate, health care providers to provide or make these materials available to patients.

4. In exercising any of his or her powers under this section, the commissioner shall consult with appropriate health care professionals, providers, consumers and patients, or organizations representing them.

5. In addition to any state funds appropriated for the program, the commissioner may accept grants from public or private sources for the program. The commissioner, in administering this section, shall seek to coordinate the program with other public and private efforts, and may undertake joint or cooperative programs with other public or private entities.

6. The commissioner may make rules and regulations necessary and appropriate for the implementation of this section.

§ 2409-a. Advisory council. 1. There is hereby established in the department the cancer detection and education program advisory council, for the purpose of advising the commissioner with regards to providing information to consumers, patients, and health care providers relating, but not limited to, breast, cervical, prostate, testicular and ovarian cancer, including signs and symptoms, risk factors, the benefits of prevention and early detection, guideline concordant cancer screening

and disease management, options for diagnostic testing and treatment, new technologies, and survivorship.

2. The advisory council shall: (a) make recommendations to the department regarding the promotion and implementation of programs under sections twenty-four hundred six and twenty-four hundred nine of this title; and (b) prior to the department providing grants from the New York State prostate and testicular cancer research and education fund, created pursuant to section ninety-five-e of the state finance law, advise the department on various components of the department's solicitation to distribute such funds, including but not limited to, the potential uses of the funds, the entities that may be eligible to apply for the funds, the recommended contract deliverables for entities receiving the funds, the recommended geographic distribution of the funds, and the recommended award amounts.

3. The commissioner shall appoint twenty-one voting members, which shall include representation of health care professionals, consumers, patients, one voting member who shall be a person who has or has had prostate or testicular cancer, one voting member who shall be a person who has or has had breast, cervical or ovarian cancer and other appropriate interests reflective of the diversity of the state, with expertise in breast, cervical, prostate, testicular and/or ovarian cancer. The commissioner shall appoint one member as a chairperson. The members of the council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in performance of their duties.

4. A majority of the appointed voting membership of the board shall constitute quorum.

5. The advisory council shall meet at least twice a year, at the request of the department.

TITLE 1-B
HEALTH RESEARCH SCIENCE BOARD

- Section 2410. Health research science board.
2411. Powers and duties of the board.
2412. Agency implementation.
2413. Biennial report.

§ 2410. Health research science board. 1. There is hereby established in the department the health research science board. The board shall be comprised of seventeen voting members, three non-voting regional members and three non-voting ex-officio members as follows:

(a) twelve voting members shall be scientists each of whom shall have either an M.D., D.O., Ph.D., or Dr.P.H. in one of the following fields: biochemistry, biology, biostatistics, chemistry, epidemiology, genetics, immunology, medicine, microbiology, molecular biology, nutrition, oncology, reproductive endocrinology, or toxicology and must currently be engaged in treating patients or conducting health research. Such members shall be appointed in the following manner: two shall be appointed by the temporary president of the senate and one by the minority leader of the senate; two shall be appointed by the speaker of the assembly and one by the minority leader of the assembly; six shall be appointed by the governor;

(b) the governor shall appoint six regional members, three of whom shall serve as full voting members and three of whom shall serve as alternative members without voting rights. Such regional members shall be persons who have or have had breast cancer, and shall be actively involved with a community-based, grass-roots breast cancer organization. Two of such appointments shall be made upon the recommendation of the temporary president of the senate and two shall be made upon the recommendation of the speaker of the assembly. One regional member shall be appointed from each of the following geographic areas of the state: Long Island, New York City, the Hudson Valley, Northern New York, Central New York and Western New York. The order of appointments and recommendations for appointments and voting rights shall rotate as follows:

(i) The governor shall appoint regional members for three year terms in the following order:

(A) Long Island, which member shall have voting rights,

- (B) Central New York, which member shall not have voting rights,
- (C) Hudson Valley, which member shall have voting rights,
- (D) Northern New York, which member shall not have voting rights,
- (E) Western New York, which member shall have voting rights, and
- (F) New York City, which member shall not have voting rights;

(ii) The governor, upon the recommendation of the temporary president of the senate, shall appoint regional members for three year terms in the following order:

- (A) Hudson Valley, which member shall not have voting rights,
- (B) Northern New York, which member shall have voting rights,
- (C) Western New York, which member shall not have voting rights,
- (D) New York City, which member shall have voting rights,
- (E) Long Island, which member shall have voting rights, and
- (F) Central New York, which member shall not have voting rights; and

(iii) The governor, upon the recommendation of the speaker of the assembly, shall appoint regional members for three year terms in the following order:

- (A) Western New York, which member shall have voting rights,
- (B) New York City, which member shall not have voting rights,
- (C) Long Island, which member shall not have voting rights,
- (D) Central New York, which member shall have voting rights,
- (E) Hudson Valley, which member shall not have voting rights, and
- (F) Northern New York, which member shall have voting rights;

(c) the governor shall appoint three non-voting ex officio members to the board, one of whom shall be the commissioner, or his or her designee, one of whom shall be the commissioner of environmental conservation, or his or her designee, and one of whom shall be the director of the Cornell University Institute for Comparative and Environmental Toxicology, or his or her designee; and

(d) the governor shall appoint one voting member who shall be a person who has or has survived breast cancer and one voting member who shall be a person who has or has survived prostate or testicular cancer.

The governor shall designate the chair of the board. The governor, temporary president of the senate, minority leader of the senate, speaker of the assembly, and minority leader of the assembly may solicit recommendations from the Centers for Disease Control and Prevention, the

National Institutes of Health, the Federal Agency For Health Care Policy and Research, and the National Academy of Sciences for appointments or recommendations for appointments to the board.

2. All members shall serve for terms of three years and may be reappointed, such terms to commence July first and expire June thirtieth; provided, however, that of the scientific members first appointed, three such members, one appointed by the governor, one appointed by the temporary president of the senate and one appointed by the speaker of the assembly, shall be appointed for terms of one year, and three such members, one appointed by the governor, one appointed by the temporary president of the senate, and one appointed by the speaker of the assembly shall be appointed for a term of two years.

The board shall convene on or before September first, nineteen hundred ninety-seven.

3. Any member, after notice and an opportunity to be heard, may be removed by the governor for neglect of duty or malfeasance in office. Any member who fails to attend three consecutive meetings of the board, unless excused by formal vote of the board, shall be deemed to have vacated his or her position.

4. Any vacancy in the board shall be filled for the unexpired term in the same manner as the original appointment.

5. A majority of the voting members of the board shall constitute a quorum for the transaction of any business or the exercise of any power or function of the board.

6. Members of the board shall not receive compensation for their services as members, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

7. For the purposes of this section the following counties shall constitute the following geographic areas:

(a) Long Island: the counties of Nassau and Suffolk.

(b) New York City: the counties of Kings, Queens, Richmond, New York and Bronx.

(c) Hudson Valley: the counties of Westchester, Rockland, Putnam, Orange, Dutchess, Ulster, Greene, Columbia, Sullivan and Delaware.

(d) Northern New York: the counties of Albany, Clinton, Essex, Franklin, Fulton, Herkimer, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

(e) Central New York: the counties of Broome, Cayuga, Chemung, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Seneca, Schuyler, St. Lawrence, Tioga, Tompkins and Wayne.

(f) Western New York: the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming, Livingston, Monroe, Ontario, Steuben and Yates.

§ 2411. Powers and duties of the board. 1. The board shall:

(a) Survey state agencies, boards, programs and other state governmental entities to assess what, if any, relevant data has been or is being collected which may be of use to researchers engaged in breast cancer research;

(b) Consistent with the survey conducted pursuant to paragraph (a) of this subdivision, compile a list of data collected by state agencies which may be of assistance to researchers engaged in breast cancer research as established in section twenty-four hundred twelve of this title;

(c) Consult with the Centers for Disease Control and Prevention, the National Institutes of Health, the Federal Agency For Health Care Policy and Research, the National Academy of Sciences and other organizations or entities which may be involved in cancer research to solicit both information regarding breast cancer research projects that are currently being conducted and recommendations for future research projects;

(d) Review requests made to the commissioner for access to information pursuant to paragraph b of subdivision one of section 33-1203 and paragraph c of subdivision two of section 33-1205 of the environmental conservation law for use in human health related research projects. Such data shall only be provided to researchers engaged in human health related research. The request made by such researchers shall include a

copy of the research proposal or the research protocol approved by their institution and copies of their institution's Institutional Review Board (IRB) or equivalent review board approval of such proposal or protocol. In the case of research conducted outside the auspices of an institution by a researcher previously published in a peer-reviewed scientific journal, the board shall request copies of the research proposal and shall deny access to the site-specific and nine-digit zip code pesticide data if the board determines that such proposal does not follow accepted scientific practice for the design of a research project. The board shall establish guidelines to restrict the dissemination by researchers of the name, address or other information that would otherwise identify a commercial applicator or private applicator or any person who receives the services of a commercial applicator;

(e) Solicit, receive, and review applications from public and private agencies and organizations and qualified research institutions for grants from the breast cancer research and education fund, created pursuant to section ninety-seven-yy of the state finance law, to conduct research or educational programs which focus on the causes, prevention, screening, treatment and cure of breast cancer and may include, but are not limited to mapping of breast cancer, and basic, behavioral, clinical, demographic, environmental, epidemiologic and psychosocial research. The board shall make recommendations to the commissioner, and the commissioner shall, in his or her discretion, grant approval of applications for grants from those applications recommended by the board. The board shall consult with the Centers for Disease Control and Prevention, the National Institutes of Health, the Federal Agency For Health Care Policy and Research, the National Academy of Sciences, breast cancer advocacy groups, and other organizations or entities which may be involved in breast cancer research to solicit both information regarding breast cancer research projects that are currently being conducted and recommendations for future research projects. As used in this section, "qualified research institution" may include academic medical institutions, state or local government agencies, public or private organizations within this state, and any other institution approved by the department, which is conducting a breast cancer research project or educational program. If a board member submits an application for a grant from the breast cancer research and education fund, he or

she shall be prohibited from reviewing and making a recommendation on the application;

(f) Consider, based on evolving scientific evidence, whether a correlation exists between pesticide use and pesticide exposure. As part of such consideration the board shall make recommendations as to methodologies which may be utilized to establish such correlation;

(g) After two years of implementation of pesticide reporting pursuant to section 33-1205 of the environmental conservation law, the board shall compare the percentage of agricultural crop production general use pesticides being reported to the total amount of such pesticides being used in this state as estimated by Cornell University, Cornell Cooperative Extension, the department of environmental conservation, and the Environmental Protection Agency;

(h) Meet at least six times in the first year, at the request of the chair and at any other time as the chair deems necessary. The board shall meet at least two times a year and as needed thereafter. Provided, however, that at least one such meeting a year shall be a public hearing, at which the general public may question and present information and comments to the board with respect to the operation of the health research science board, the breast cancer research and education fund, and pesticide reporting established pursuant to sections 33-1205 and 33-1207 of the environmental conservation law. At such hearing, the commissioner of the department of environmental conservation or his or her designee shall make a report to the board with respect to the efficiency and utility of pesticide reporting established pursuant to sections 33-1205 and 33-1207 of the environmental conservation law. Should the existing bylaws be amended by the board, any such amendments shall be consistent with the revisions of this paragraph;

2. The commissioner shall request that the department of environmental conservation compile information pursuant to paragraph b of subdivision one of section 33-1203 of the environmental conservation law as necessary to fulfill board approved requests, pursuant to paragraph (d) of subdivision one of this section.

3. The commissioner shall provide the board with such staff assistance

and support services as are necessary for the board to perform the functions required of it under this section.

§ 2412. Agency implementation. All state agencies, including, but not limited to, the departments of agriculture and markets, environmental conservation, and health, shall review their programs and operations (pursuant to guidelines established by the board) to determine whether they currently collect data which may be of use to researchers engaged in breast, prostate or testicular cancer research. Any agency collecting such data shall forward a description of the data to the health research science board.

§ 2413. Biennial report. The commissioner shall submit a report on or before January first commencing in nineteen hundred ninety-nine, and biennially thereafter, to the governor, the temporary president of the senate and the speaker of the assembly concerning the operation of the health research science board. Such report shall include recommendations from the health research science board including, but not limited to, the types of data that would be useful for breast cancer researchers and whether private citizen use of residential pesticides should be added to the reporting requirements. The report shall also include a summary of research requests granted or denied. In addition, such report shall include an evaluation by the commissioner, the commissioner of the department of environmental conservation and the health research science board of the basis, efficiency and scientific utility of the information derived from pesticide reporting pursuant to sections 33-1205 and 33-1207 of the environmental conservation law and recommend whether such system should be modified or continued. The report shall include a summary of the comments and recommendations presented by the public at the board's public hearings.

TITLE II

STATE INSTITUTE FOR THE STUDY OF MALIGNANT DISEASES

Section 2420. Cancer institute; continued.

2421. Cancer institute; functions; powers and duties.

2422. Cancer institute; commissioner's duty to publish reports.

2423. Cancer institute; administration of gifts and trusts.

§ 2420. Cancer institute; continued. The state institute for the study of malignant diseases, known as the Roswell Park Cancer Institute, is hereby continued under the management and control of the department.

§ 2421. Cancer institute; functions; powers and duties. 1. The state institute for the study of malignant diseases, shall conduct investigations of the cause, mortality, treatment, prevention and cure of cancer and allied diseases.

2. Persons afflicted with cancer or allied diseases, may be received free of charge in the said state institute for study, experimental or other treatment, under regulations established by the commissioner.

3. The direction of related research work in whole or in part toward malignant diseases in connection with conditions other than cancer shall not be a violation of the conditions of the grants made pursuant to the provisions of chapter one hundred twenty-eight of the laws of nineteen hundred eleven.

§ 2422. Cancer institute; commissioner's duty to publish reports. The commissioner shall publish from time to time the result of the investigations by the state institute for the study of malignant diseases for the benefit of humanity, and from time to time, he shall collate its publications in a scientific report for distribution to scientific organizations and to medical scientists and qualified members of the medical profession.

§ 2423. Cancer institute; administration of gifts and trusts. The commissioner, as the successor of the board of trustees of the state

institute for the study of malignant diseases, shall execute and administer any gifts, transfer or trust heretofore made to or for the benefit of such institute and may receive gifts, legacies and bequests, and use the same for the advancement of the subjects and purposes of the institute.

ARTICLE 24-A

PROTECTION OF HUMAN SUBJECTS

Section 2440. Policy and purpose.

2441. Definitions.

2442. Informed consent.

2443. Conduct of human research.

2444. Human research review committees.

2445. Applicability.

2446. Rules and regulations.

§ 2440. Policy and purpose. The use of human subjects in medical research projects has brought about many beneficial scientific advances resulting in the increased health and well-being of the human race. Safeguarding the rights and welfare of individual human subjects in the conduct of these human research projects is a matter of vital state concern. Every human being has the right to be protected against the possible conduct of medical or psychological research upon his body without his voluntary informed consent. Human research may effect dangerous and unanticipated results causing irreversible damage to the human subject. Accordingly, it shall be the policy of this state to protect its people against the unnecessary and improper risk of pain, suffering or injury resulting from human research conducted without their knowledge or consent.

§ 2441. Definitions. For the purposes of this article: 1. "Human subject" shall mean any individual who may be exposed to the possibility of injury, including physical, psychological or social injury, as a consequence of participation as a subject in any research, development,

or related activity which departs from the application of those established and accepted methods necessary to meet his needs or which increases the ordinary risk of daily life including the reecognized risks inherent in a chosen occupation or field of service.

2. "Human research" means any medical experiments, research, or scientific or psychological investigation, which utilizes human subjects and which involves physical or psychological intervention by the researcher upon the body of the subject and which is not required for the purposes of obtaining information for the diagnosis, prevention, or treatment of disease or the assessment of medical condition for the direct benefit of the subject. Human research shall not, however, be construed to mean the conduct of biological studies exclusively utilizing tissue or fluids after their removal or withdrawal from a human subject in the course of standard medical practice, or to include epidemiological investigations.

3. "Fluid" means a normal body excretion or any fluid formed by normal or pathological body processes obtained during diagnostic or therapeutic procedures conducted for the benefit of the human subject.

4. "Tissue" means part or all of any organ of a human subject removed during a diagnostic or therapeutic procedure conducted for the benefit of the human subject.

5. "Voluntary informed consent" means the legally effective knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress or other form of constraint or coercion. With regard to the conduct of human research, the basic elements of information necessary to such consent include:

(a) a fair explanation to the individual of the procedures to be followed, and their purposes, including identification of any procedures which are experimental;

(b) a description of any attendant discomforts and risks reasonably to be expected;

(c) a description of any benefits reasonably to be expected;

(d) a disclosure of any appropriate alternative procedures that might be advantageous for the individual;

(e) an offer to answer any inquiries by the individual concerning the procedures; and

(f) an instruction that the individual is free to withdraw his consent and to discontinue participation in the human research at any time without prejudice to him.

6. "Researcher" means any person licensed under title VIII of the education law to perform diagnosis, treatment, medical services, prescription or therapeutic exercises with regard to or upon human beings, or any other person deemed appropriately competent and qualified by a human research review committee as provided by section twenty-four hundred forty-four of this chapter.

§ 2442. Informed consent. No human research may be conducted in this state in the absence of the voluntary informed consent subscribed to in writing by the human subject. If the human subject be a minor, such consent shall be subscribed to in writing by the minor's parent or legal guardian. If the human subject be otherwise legally unable to render consent, such consent shall be subscribed to in writing by such other person as may be legally empowered to act on behalf of the human subject. No such voluntary informed consent shall include any language through which the human subject waives, or appears to waive, any of his legal rights, including any release of any individual, institution or agency, or any agents thereof, from liability for negligence.

§ 2443. Conduct of human research. No one except a researcher shall conduct human research in this state.

§ 2444. Human research review committees. 1. Each public or private institution or agency which conducts, or which proposes to conduct or authorize, human research, shall establish a human research review committee. Such committee shall be composed of not less than five

persons, approved by the commissioner, who have such varied backgrounds as to assure the competent, complete and professional review of human research activities conducted or proposed to be conducted or authorized by the institution or agency. No member of a committee shall be involved in either the initial or continuing review of an activity in which he has a conflicting interest, except to provide information required by the committee. No committee shall consist entirely of persons who are officers, employees, or agents of, or who are otherwise associated with the institution or agency, apart from their membership on the committee, and no committee shall consist entirely of members of a single professional group.

2. The human research review committee in each institution or agency shall require that institution or agency to promulgate a statement of principle and policy in regard to the rights and welfare of human subjects in the conduct of human research, and the committee and the commissioner shall approve that statement prior to its taking effect. The committee shall review each proposed human research project to determine (1) its necessity; (2) that the rights and welfare of the human subjects involved are adequately protected, (3) that the risks to the human subjects are outweighed by the potential benefits to them or by the importance of the knowledge to be gained; (4) that the voluntary informed consent is to be obtained by methods that are adequate and appropriate, and (5) that the persons proposed to conduct the particular medical research are appropriately competent and qualified. The committee shall periodically examine each existing human research project with regard to the proper application of the approved principles and policies which the institution or agency has promulgated. The committee shall report any violation to the commissioner. In addition to the voluntary informed consent of the proposed human subject as required by section twenty-four hundred forty-two of this chapter, the consent of the committee and the commissioner shall be required with relation to the conduct of human research involving minors, incompetent persons, mentally disabled persons and prisoners.

3. Each person engaged in the conduct of human research or proposing to conduct human research shall affiliate himself with an institution or

agency having a human research review committee, and such human research as he conducts or proposes to conduct shall be subject to review by such committee in the manner set forth in this section.

§ 2445. Applicability. 1. The provisions of this article shall not apply to the conduct of human research which is subject to, and which is in compliance with, policies and regulations promulgated by any agency of the federal government for the protection of human subjects.

2. Upon attestation, satisfactory to the commissioner, by an institution or agency that such institution or agency (a) conducts human research that is subject to and is in compliance with policies and regulations promulgated by any agency of the federal government for the protection of human subjects, and (b) conducts or proposes to conduct or authorize human research, which is not subject to but does or shall comply with federal policies and regulations, the commissioner may deem, subject to conditions, such institution or agency's human research in compliance with this article. Such attestation shall be submitted annually on or before January first to the department on a form prescribed by the commissioner.

§ 2446. Rules and regulations. The commissioner shall have the power to promulgate such rules and regulations as shall be necessary and proper to effectuate the purposes of this article.

ARTICLE 24-B

INFORMATION PROGRAM ON DIOXIN

Section 2475. Special policies with respect to dioxin exposure.

§ 2475. Special policies with respect to dioxin exposure. 1. For the purpose of identifying persons who were exposed to an herbicide containing dioxin and for the purpose of compiling data on the health effects of this exposure, the commissioner of health shall:

(a) establish, promote and maintain a public information program on dioxin. Such program shall include, but may not be limited to, an effort to contact Vietnam era veterans and employees of the public and private sectors within the state who were exposed to an herbicide containing dioxin;

(b) initiate an epidemiological study of the health effects of exposure to herbicides containing dioxin;

(c) maintain a central data bank within the department for information collected on the health effects of exposure to dioxin and for the cataloguing of existing scientific and medical literature on the health effects of this exposure; and

(d) initiate education for health professionals to assist them in understanding the potential risks and state-of-the-art knowledge with regard to detection, diagnosis and treatment of acute and chronic symptoms associated with dioxin exposure.

2. The commissioner may request and shall receive from any department, division, board, bureau, commission or agency of the state or of any political subdivision thereof such assistance and data as will enable him to properly carry out his activities hereunder and effectuate the purposes herein set forth. The commissioner may also enter into any contract for services as he deems necessary with a private agency or concern upon said terms and conditions as he deems appropriate. Information concerning patient and medical data provided to the commissioner pursuant to this subdivision shall be kept confidential according to the provisions of paragraph (j) of subdivision one of section two hundred six of this chapter.

ARTICLE 24-C

INFORMATION PROGRAM ON LOW-LEVEL RADIOACTIVE WASTE

Section 2485. Program to inform and educate the public on low-level radioactive waste.

§ 2485. Program to inform and educate the public on low-level radioactive waste. In consultation and cooperation with the advisory

committee established pursuant to section 29-0501 of the environmental conservation law, and with the department of environmental conservation, the commissioner of health shall plan and carry out a statewide public information program on the public health and safety implications of low-level radioactive waste management. The content of such program shall include a basic explanation of the types of materials which comprise low-level radioactive waste and why such materials require special handling and care; and reasonably detailed explanations of alternative disposal methods and their probable effects.

ARTICLE 24-D

NEW YORK STATE OCCUPATIONAL HEALTH CLINICS OVERSIGHT COMMITTEE

Section 2490. Oversight committee.

2490-a. Occupational health clinic advisory committees.

§ 2490. Oversight committee. 1. There is hereby established the occupational health clinics oversight committee to be comprised of the following persons or their designees: the commissioner of health; the commissioner of labor; the chairperson of the workers' compensation board; six persons appointed by the governor, one of whom shall be on nomination of the New York state American federation of labor-congress of industrial organizations, and one of whom shall be on the nomination of the business council of the state of New York; two persons appointed by the temporary president of the senate; two persons appointed by the speaker of the assembly; one person appointed by the minority leader of the senate and one person appointed by the minority leader of the assembly. The governor shall designate a chairperson from among the members of the committee. The initial appointments shall be made on or before September first, two thousand eight.

2. The committee shall meet at least four times a year. Special meetings may be called by the chairperson.

3. Members of the oversight committee shall receive no compensation for their services, but shall be allowed their actual and necessary

expenses incurred in the performance of their duties hereunder.

4. Vacancies shall be filled in the same manner as the original appointments.

5. The committee shall make recommendations to the governor and the legislature on or before September thirtieth, two thousand nine, regarding:

- (a) statewide needs to be met by the network;
- (b) coordination of clinic activities with not-for-profit, private sector concerns and state agencies, including but not limited to an evaluation of current jurisdictional and oversight responsibilities;
- (c) coordination and sharing of clinic resources and services;
- (d) dissemination of research results and educational information;
- (e) identification of funding sources for the network;
- (f) the activities of the clinics and their effectiveness in meeting the objectives as set forth in statute and in clinic specific contracts with the state;
- (g) local, regional, occupation or business sector specific needs that may be met by one or more clinic;
- (h) other issues as determined by the oversight committee; and
- (i) incorporation of provisions to implement its recommendations in requests for applications of state funding for occupational health clinics.

§ 2490-a. Occupational health clinic advisory committees. The chief executive officer of every clinic in the occupational health clinic network shall convene an advisory committee consisting of two local representatives each of business, labor unions, public health agencies and community groups which shall be selected in consultation with the occupational health clinics oversight committee. The oversight committee will assist in the development of policies, the creation and implementation of a targeted outreach plan for working with business, unions and workers, an assessment of clinic-specific funding needs and potential funding sources, and overall guidance for the clinics on an ongoing basis.

ARTICLE 24-E

INFORMATION ABOUT HYSTERECTOMY

- Section 2495. Legislative findings and intent.
2496. Written summary regarding hysterectomy.
2497. Availability of written summary.
2498. Provision of summary by physician.
2499. Informed consent.
2499-a. Exception.

§ 2495. Legislative findings and intent. Hysterectomy is one of the most common major surgical procedures performed on women and is a commonly recommended treatment for some gynecological disorders, such as uterine leiomyofibroma, endometriosis, disorders of menstruation, and uterine neoplasms. Some disorders, depending on the patient's diagnosis and situation, may be managed with alternative treatments. In an effort to promote patients' involvement in health care decisions and to promote informed consultation with their physician or other health care practitioner, the department of health shall make available information which describes the medical diagnoses that are commonly treated with a hysterectomy, the various hysterectomy procedures, and treatment alternatives to the diagnoses commonly treated with hysterectomy.

§ 2496. Written summary regarding hysterectomy. The commissioner, in consultation with the medical society of the state of New York, consumers and others knowledgeable on the topic of hysterectomy shall develop a standardized written summary which shall explain:

1. the common diagnoses for which hysterectomy is a common treatment including but not limited to uterine leiomyofibroma, endometriosis, disorders of menstruation, premalignant or malignant changes in uterus or cervix and salpingo-oophoritis;
2. alternative treatments to hysterectomy for such diagnoses, in

accordance with accepted medical practices;

3. the types of hysterectomy including radical, subtotal abdominal, total abdominal and vaginal;

4. the common physiological changes, side effects, risks and benefits which result after each type of hysterectomy or alternative is performed;

5. that the hysterectomy is irreversible, results in infertility and the end of menstruation; and

6. an oophorectomy, a treatment often associated with hysterectomy, including unilateral, bilateral and salpingo-oophorectomy.

§ 2497. Availability of written summary. The commissioner shall make the summary provided for in section twenty-four hundred ninety-six of this article available free of charge to all clinics, health maintenance organizations, hospitals, and physician offices.

§ 2498. Provision of summary by physician. The summary shall be provided by a physician to each person under such physician's care, when a hysterectomy is under consideration for that person.

§ 2499. Informed consent. Nothing in this section shall be construed to create a cause of action for lack of informed consent in any instance in which such cause of action would be limited by section twenty-eight hundred five-d of this chapter.

§ 2499-a. Exception. The dispensing of the standard written summary shall not pertain when the hysterectomy is performed in a situation of imminent danger in which the physician determines prior dispensing is not possible or feasible.

ARTICLE 25

MATERNAL AND CHILD HEALTH

- Title
- I. General provisions (§§ 2500--2509-d).
 - I-A. Child health insurance plan (§§ 2510-2511).
 - 1-B. Adolescent pregnancy prevention and services program (§§ 2515--2515-c).
 - II. Prenatal care (§§ 2522-2532).
 - II-A. Early intervention program for infants and toddlers with disabilities and their families (§§ 2540--2559-b).
 - III-A. Community doula expansion program (§§ 2560-2563).
 - IV. Institutions for children (§§ 2570-2575).
 - V. Children with physical disabilities (§§ 2580-2584).
 - VI*. Federal child care and adult food program (§§ 2585-2589).
 - VI. Emergency nutrition aid program for pregnant women and adolescents (§§ 2590-2592)
 - VII. Youth sports (§ 2595).
 - VIII. Childhood obesity prevention program (§§ 2599-a--2599-d).

TITLE I

GENERAL PROVISIONS

- Section 2500. Maternal and child health; duties of commissioner.
- 2500-a. Test for phenylketonuria and other diseases and conditions.
 - 2500-b. Sudden infant death syndrome.
 - 2500-c. Special programs with respect to diethylstilbestrol.
 - 2500-d. New York state poison control network.
 - 2500-e. Pregnant women, blood test for hepatitis B; follow-up care.
 - 2500-f. Human immunodeficiency virus; testing of newborns.
 - 2500-f-1. Special program for HIV services for women and children, including adolescents.

- 2500-g. Newborn infant hearing screening.
- 2500-h. Statewide perinatal data system.
- 2500-h*2. Anaphylactic policy for school districts and child care providers.
- 2500-i. Child food choking prevention.
- 2500-j. Autism spectrum disorders; screening of children.
- 2500-k. Maternal depression.
- 2500-l. Pregnant people, blood test for hepatitis C virus (HCV); follow-up care.
- 2500-m. Access to doulas.
- 2501. Health and welfare services to all children; duty of local boards.
- 2502. Report of certain conditions.
- 2503. Drug information to be furnished expectant mothers.
- 2504. Enabling certain persons to consent for certain medical, dental, health and hospital services.
- 2504-a. Hepatitis B immunization of a minor.
- 2504-b. Information concerning pelvic exams.
- 2505. Human breast milk; collection, storage and distribution; general powers of the commissioner.
- 2505-a. Rights of breastfeeding mothers.
- 2505-b. Lactation accommodations in airports.
- 2506. Obstetric and pediatric practitioner incentive demonstration program.
- 2507. Special supplemental nutrition program for women, infants and children; specialty formula.
- 2508. Newborn health and safe sleep study.
- 2509. Maternal mortality review board.
- 2509-a. Corded window blind leaflet.
- 2509-c. Availability of adverse childhood experiences services.
- 2509-d. Veterans reproductive mental health care.

§ 2500. Maternal and child health; duties of commissioner. 1. The commissioner shall act in an advisory and supervisory capacity, in matters pertaining to the safeguarding of motherhood, the prevention of

maternal, perinatal, infant and child mortality, the prevention of diseases, low birth weight, childhood obesity, and defects of childhood and the promotion of maternal, prenatal and child health, including care in hospitals, and shall administer such services bearing on the health of mothers and children for which funds are or shall hereafter be made available.

2. The commissioner shall establish minimum standards in accordance with established and accepted medical principles for local maternal and child health services administered by or under the general supervision of the commissioner.

3. a. The commissioner shall, in conjunction with hospitals, obstetricians, midwives, doulas, maternal health care provider organizations; mental health care provider organizations; and any additional stakeholders that the commissioner deems necessary, evaluate and make recommendations related to the development of maternal health care and birthing best practices which support each patient receiving the highest quality of care. These recommendations shall include, but not be limited to, best practices for every patient to receive:

(i) fair, courteous and respectful culturally competent care free of discrimination;

(ii) accurate and judgment-free advice and recommendations that allow for informed decision making and consent regarding care and treatment, including risks, benefits, outcomes and alternative procedures;

(iii) clear, concise and easily understood information about their care and treatment outcomes, medical team and birthing options, the policies and procedures of the hospital or birthing center, and resources available to them;

(iv) an opportunity to discuss their birthing preferences with their care team and have such preferences documented; and

(v) adequate support during their pregnancy, labor and childbirth, including access to doula and mental health services.

b. No later than one year after the effective date of this subdivision the commissioner shall publish such recommendations on the department of health's website and update all relevant materials provided to the

public through the department to reflect these standards. Such recommendations shall be updated at least once after publishing and as necessary thereafter.

4. In conjunction with the state department having general supervision, the commissioner may make or may cause to be made investigation of the conditions affecting the health of children in institutions for day care or domiciliary care. If he shall find any conditions detrimental to health in such institutions, he shall make and report recommendations thereon to the appropriate state department.

5. The commissioner shall cooperate with other state departments having jurisdiction over matters affecting the health of mothers and children, to the end that existing activities may be coordinated and duplication of effort avoided. He shall cooperate with and stimulate local agencies, public and private, in promoting such measures and undertakings as may be designed to accomplish the purposes of this section.

§ 2500-a. Test for phenylketonuria and other diseases and conditions.

1. It shall be the duty of the administrative officer or other person in charge of each institution caring for infants twenty-eight days or less of age and the person required in pursuance of the provisions of section forty-one hundred thirty of this chapter to register the birth of a child, to cause to have administered to every such infant or child in its or his care a test for diseases and conditions designated by the commissioner under regulations of the commissioner, and for:

- (a) Phenylketonuria.
- (b) Homozygous sickle cell disease.
- (c) Hypothyroidism.
- (d) Branched-chain ketonuria.
- (e) Galactosemia.
- (f) Homocystinuria.
- (g) Critical congenital heart defects through pulse oximetry screening.
- (h) With regard to any newborn infant who is identified as, or

suspected of, having a hearing impairment as a result of a screening conducted pursuant to section twenty-five hundred-g of this title, a urine polymerase chain reaction (PCR) test for cytomegalovirus, unless the parent of the infant objects thereto; provided that if the commissioner determines that another test for cytomegalovirus is diagnostically equivalent to or better than the urine polymerase chain reaction test, the commissioner may, by regulation under this section, allow or require the use of that other test.

(i) Adrenoleukodystrophy.

(j) Glucose-6-phosphate dehydrogenase deficiency using a quantitative enzymatic test or other diagnostic test in cases where: the newborn infant presents with hemolytic anemia, hemolytic jaundice, or early-onset increasing neonatal jaundice, that is, jaundice (bilirubin level greater than fortieth percentile for age in hours) persisting beyond the day of birth through the week after birth; the newborn infant has been admitted to the hospital for jaundice following birth; or the biological parent of the newborn infant indicates a family, racial, or ethnic risk of glucose-6-phosphate dehydrogenase deficiency, including having significant African, Asian, Mediterranean, or Middle Eastern ancestry.

(k) Duchenne muscular dystrophy using a test validated by the Wadsworth center for laboratories and research.

2. Testing, the recording of the results of such tests, tracking, follow-up reviews and educational activities shall be performed at such times and in such manner as may be prescribed by the commissioner. The commissioner shall promulgate regulations setting forth the manner in which information describing the purposes of the requirements of this section shall be disseminated to parents or a guardian of the infant tested.

3. The provisions of this section shall not apply in the case of any infant or child whose parent or guardian is a member of a recognized religious organization whose teachings and tenets are contrary to the testing herein required and who notifies the person charged with having such test administered of his objection thereto.

§ 2500-b. Sudden infant death syndrome. (a) Declaration of policy.

Occurrence of sudden deaths of infants is a tragedy for the child, the family and the community, and a matter of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, the department of health shall have the central and comprehensive responsibility for the development and administration of the state's policy with respect thereto.

(b) The commissioner shall establish a program to study the sudden deaths of infants which are unexpected by medical history, and for which adequate causes of death have not been demonstrated.

(c) Such program may initially consist of pilot projects which shall include epidemiological investigation, family counseling and evaluation in order to identify the major risk factors in sudden infant deaths with the objective of preventing such deaths.

§ 2500-c. Special programs with respect to diethylstilbestrol. 1. For the purpose of identifying persons who have been exposed to the potential hazards and afflictions of diethylstilbestrol, and for the purpose of educating the public concerning the symptoms and prevention of associated malignancies, the commissioner shall establish, promote and maintain a public information campaign on diethylstilbestrol. Such campaign shall be conducted throughout the state and shall include but not be limited to a concerted effort at reaching those persons or the offspring of persons who have been exposed to diethylstilbestrol in order to encourage them to seek medical care for the prevention or treatment of any malignant condition.

2. (a) The commissioner shall designate and enter into contracts with providers of health care for the purpose of establishing regional screening programs for diethylstilbestrol exposed persons. In determining the provider with which to contract, the commissioner shall consider such provider's compliance with state and federally mandated standards, the location in relation to the geographical distribution of persons exposed to diethylstilbestrol, and the capacity of such provider

to properly screen for breast cancer, vaginal cancer, cervical cancer, vaginal adenosis, testicular cancer and any other malignancy and abnormal conditions resulting from DES exposure.

(b) Each contract for a regional screening program shall be upon such terms and conditions as the commissioner determines, provided, however, that expenses incurred shall be reimbursed by the state after applying against the total cost of screening and diagnosis the amounts received from third party payers and less any fee charged each person receiving such services where the commissioner shall determine a sliding fee scale based on ability to pay.

3. Each provider of health care that enters into a contract as provided for in this section shall conduct a training program in conjunction with the department for purposes of instructing physicians, physician assistants and nurses within the respective health systems agency in the detection, diagnosis, treatment and prevention of diethylstilbestrol exposed persons.

4. The bureau of cancer control within the health department shall establish and maintain a registry of women who took diethylstilbestrol during pregnancy and their offspring who were exposed to diethylstilbestrol prenatally for the purpose of follow-up care and treatment of long term problems associated with diethylstilbestrol exposure. Enrollment in the registry shall be upon a voluntary basis.

5. The commissioner may request and shall receive from any department, division, board, bureau, commission or agency of the state or of any political subdivision thereof such assistance and data as will enable him to properly carry out his activities hereunder and effectuate the purposes herein set forth. The commissioner may also enter into any contract for services as he deems necessary with a private agency or concern upon said terms and conditions as he deems appropriate.

7. Special programs as provided for in this section shall be conducted within the appropriation made therefor.

§ 2500-d. New York state poison control network. 1. For the purposes of reducing the incidence, severity and expenditures for accidental, homicidal, suicidal or environmental poisoning; educating the public concerning the prevention and treatment of hazardous exposures; and organizing poison control activities on a regional basis in order to avoid duplication and waste, the commissioner shall designate facilities within the state as regional poison control centers.

2. The commissioner shall consider the following criteria in designating regional poison control centers: compliance or expected compliance with state poison control standards; location in relation to the geographical distribution of persons to be served; the need for expanded poison control services in the area to be served by the provider; whether the facility is presently providing poison control services; and the capacity of such providers to deliver and coordinate poison prevention information and poison treatment to the general public.

3. The commissioner shall establish minimum standards for designation as a regional poison control center. Such standards shall include:

a. services to be provided which may include:

(i) dissemination of expert information and consultation services to professional personnel on the diagnosis, treatment, and management of any suspected or actual poisonings;

(ii) dissemination of information, emergency first aid, and referral services to the general public;

(iii) coordination, assurance and monitoring of poison prevention and medical management programs for the professional community and the general public in the region it serves; and

(iv) collection of uniform data and research activity to enhance poison control management;

b. staffing requirements including the number, qualifications and training of personnel;

c. operational requirements including availability of and access to

services and informational resources, public and professional education, and protocols;

d. comprehensive treatment capabilities and a categorized system of treatment facilities for the region;

e. health professional outreach program; and

f. regional data collection system including a method of insuring the confidentiality of such data as is otherwise required by law.

4. The department shall make an annual report to the legislature of its findings and recommendations concerning the effectiveness, impact and benefits derived from the programs as established pursuant to this section. Such report shall be submitted on or before the first day of February and shall contain evaluations of such programs.

5. The commissioner shall appoint a committee to advise the department on matters pertaining to poison prevention and control. Membership on such committee shall include directors of regional poison control centers, consumers, industrial representatives, and representatives of state and federal agencies involved in poison safety.

6. A general hospital which is designated as a regional poison control center shall submit a budget indicating the costs of operating such center. Costs determined by the commissioner to be necessary and reasonable in order to comply with the requirements of this section shall be reimbursable and shall be allocated to costs of general hospital emergency services. Such reimbursable costs for a rate period shall be considered in the calculation of rates of payment for emergency services of a general hospital for such rate period in accordance with subdivision two of section twenty-eight hundred seven of this chapter without application of the maximum payment for the operating cost component of rates of payment for emergency services. Notwithstanding any inconsistent provision of law, reimbursable costs of a general hospital of operating a regional poison control center determined pursuant to this subdivision for annual rate periods beginning on or

after January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-six allocable to emergency services provided to persons within such payor categories as specified in paragraphs (a), (b) and (c) of subdivision one of section twenty-eight hundred seven-c of this chapter for inpatient hospital services, excluding governmental agencies, shall be included in the determination of inpatient rates of payment for such payors, excluding governmental agencies, and rates of payment determined in accordance with section twenty-eight hundred seven-c of this chapter shall be adjusted on a hospital-specific basis in accordance with rules and regulations adopted by the state hospital review and planning council, subject to the approval of the commissioner, to reflect such costs and maximum inpatient charges of such general hospital computed in accordance with such section shall be adjusted accordingly; and cost based rates of payment for emergency services for such payors, other than governmental agencies, shall be calculated excluding costs of operating a regional poison control center.

7. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is authorized to make grants, within amounts available therefor, to general hospitals designated as regional poison control centers to assist such general hospitals to meet reasonable costs of operation of the regional poison control center.

§ 2500-e. Pregnant women, blood test for hepatitis B; follow-up care.

1. At the time that a blood sample is taken to be tested for syphilis pursuant to section twenty-three hundred eight of this chapter, every physician or other authorized practitioner attending a pregnant woman in the state shall, in addition, submit or cause to be submitted such sample to an approved laboratory for a standard serological test for hepatitis B surface antigen.

2. The term "approved laboratory" means a laboratory approved for the purpose as herein provided by the department, or in the city of New York by the department of health of such city.

3. A standard serological test for hepatitis B surface antigen is one recognized as such by the department or in the city of New York by the department of health of such city.

4. The physician or other authorized practitioner attending a pregnant woman shall record the hepatitis B surface antigen test results prominently in the pregnant woman's medical record at or before the time of hospital admission for delivery.

5. If, at the time of hospital admission for delivery, hepatitis B surface antigen test results are not available, the hospital shall arrange immediate testing of the mother with results available within twenty-four hours, or as soon thereafter as practicable, but in no event longer than forty-eight hours.

6. It shall be the duty of the administrative officer or other person in charge of each institution caring for infants twenty-eight days of age or less to report the hepatitis B surface antigen test results of all mothers of newborn children to the department in such a manner as may be required by the commissioner.

7. If the mother of a newborn infant has tested positive for hepatitis B surface antigen, the physician or other authorized practitioner attending the infant shall offer or cause to be offered immunizing doses of hepatitis B vaccine and hepatitis B immune globulin to the newborn within twelve hours of birth or whenever the infant is stable physiologically and immunizing doses of hepatitis B vaccine and follow-up vaccine in accordance with the schedule specified by the commissioner. If the mother's hepatitis B surface antigen test results were unavailable when the mother was admitted to a hospital for delivery, the physician or other authorized practitioner attending the infant shall offer or cause to be offered immunizing doses of hepatitis B vaccine and hepatitis B immune globulin for the newborn immediately upon receiving results showing that the mother has tested positive for hepatitis B surface antigen and offer immunizing doses of hepatitis B vaccine and follow-up vaccine in accordance with the schedule specified by the commissioner.

8. The parent or guardian of any child born to a mother positive for hepatitis B surface antigen shall have administered to such child immunizing doses of hepatitis B immune globulin at birth and hepatitis B vaccine as well as follow-up hepatitis B vaccine in accordance with the schedule specified by the commissioner.

9. If the parent or guardian of such child is unable to pay for the services of a private physician or other authorized practitioner, such person shall present such child to the health officer of the county in which the child resides, who shall then administer the follow-up hepatitis B vaccine without charge.

10. If any licensed physician or nurse practitioner certifies that a follow-up dose of hepatitis B vaccine may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to such child's health.

11. The provision of this section relating to immunization shall not apply in the case of any newborn infant whose parent or guardian holds genuine and sincere religious beliefs which prohibit immunization and who notifies the person charged with administering such immunization of the religious objection thereto.

12. The commissioner of health shall promulgate such rules and regulations as are necessary to carry out the requirements of this section.

§ 2500-f. Human immunodeficiency virus; testing of newborns. 1. In order to improve the health outcomes of newborns, and to improve access to care and treatment for newborns infected with or exposed to human immunodeficiency virus (HIV) and their mothers, the commissioner shall establish a comprehensive program for the testing of newborns for the presence of human immunodeficiency virus and/or the presence of antibodies to such virus.

2. The commissioner shall promulgate regulations governing the implementation of the program required pursuant to subdivision one of this section, including the administration of testing, counseling, tracking, disclosure of test results pursuant to section twenty-seven hundred eighty-two of this chapter, follow-up reviews, and educational activities relating to such testing.

§ 2500-f-1. Special program for HIV services for women and children, including adolescents. The commissioner, pursuant to a request for proposal, shall make grants to programs to provide HIV services for women and children, including adolescents which may include outreach and education concerning HIV infection, modes of transmission, the benefits of early diagnosis and medical intervention and the availability of services in the community for women and children, including adolescents, including those in need of prenatal and postpartum services. Such programs may make referrals for and may deliver medical and other appropriate services to assist such women and children, including adolescents. The commissioner is authorized to make grants within amounts available therefor to hospitals, community-based organizations and community service programs for programs authorized under this section.

§ 2500-g. Newborn infant hearing screening. 1. The commissioner shall, within the amounts appropriated therefor, and in consultation with health care providers or their representatives, establish a program to screen newborn infants for hearing problems. This program shall incorporate consensus medical guidelines and protocols, reflecting the most cost-effective methods for detecting hearing problems as early as possible in an infant's life. The program shall provide for follow-up screening including referrals for screening or care. Such program shall also provide for the reimbursement of health care providers performing such services under the program.

2. It shall be the duty of the administrative officer or other

designated person at each facility licensed pursuant to article twenty-eight of this chapter caring for newborn infants, to either administer a hearing screening upon each such newborn infant or, if the facility is not reasonably able to screen a newborn infant prior to discharge, provide a referral for the newborn infant to obtain the service following discharge. Facilities subject to the provisions of this section that administer a newborn infant hearing screening shall report to the department in a manner and format required by the commissioner:

- (a) the results of each newborn infant hearing screening performed;
- (b) instances in which a newborn infant hearing screening is not performed on a newborn infant before such infant is discharged from the facility; and
- (c) such other information or data as may be required by the commissioner pursuant to regulation to fulfill the purposes of this section.

3. Any person who performs a newborn infant hearing screening, meaning a hearing screening performed upon a newborn infant, other than a hearing screening administered by a facility pursuant to subdivision two of this section, or upon a child under six months of age, shall report to the department, in a manner and format required by the commissioner pursuant to regulation:

- (a) the results of each newborn infant hearing screening performed; and
- (b) such other information or data as may be required by the commissioner to fulfill the purposes of this section.

4. The department shall collect and maintain the newborn infant hearing results and information provided pursuant to subdivisions two and three of this section in a statewide information system developed by the department for such purpose.

5. The department shall provide access to newborn infant hearing screening results and other information or data as determined by the department to the following persons or entities for the following purposes:

(a) The commissioner of health for the purposes of outreach, quality improvement and accountability, research, and epidemiological studies and disease control;

(b) The commissioner of health and mental hygiene for the city of New York and local health departments for purposes of outreach, quality improvement and accountability, research, epidemiological studies and disease control;

(c) Health care professionals licensed under title eight of the education law and their designees for the purposes of determining, with respect to newborn infants or children under their care, whether a newborn infant hearing screening was performed, whether a re-screening or other follow-up is necessary, to enter newborn infant hearing screening results and data, and for treatment purposes;

(d) A facility licensed under article twenty-eight of this chapter that administers a newborn infant hearing screening for the purposes of entering newborn infant hearing screening results and data into the statewide information system and determining whether a screening, re-screening or other follow-up is necessary;

(e) Third party payers as defined in paragraph (f) of subdivision two of section twenty-one hundred sixty-eight of this chapter for the purposes of quality assurance, accountability and outreach relating to enrollees covered by the third party payer; and

(f) A commissioner of a local social services district with regard to newborn infants or children in his or her legal custody.

6. All newborn hearing screening results and other information or data maintained by the department shall be confidential and shall not be disclosed except as provided for in this section. The parent or guardian of a newborn infant or child for whom a newborn infant hearing screening was performed may obtain a copy of the newborn infant hearing screening results from:

(a) The facility that administered the newborn infant hearing screening;

(b) The person who performed the screening, if the screening was not administered at a facility subject to the provisions of this section; or

(c) The statewide information system that maintains the results by requesting the record pursuant to procedures established by the

commissioner in regulation.

*** § 2500-h. Statewide perinatal data system.** 1. In order to support quality care at all hospitals with obstetric services, the department is authorized to provide de-identified information for all births at each affiliate hospital in each regional perinatal center's network to the regional perinatal center and the affiliate, except that such information shall include zip code and a unique identifier such as medical record number.

2. The information when received by the department shall be used solely for the purpose of improving quality of care and shall not be subject to release under article six of the public officers law, and where applicable, shall be subject to the confidentiality provisions of section twenty-eight hundred five-m of this chapter, except that the release of birth certificate information shall be subject to section forty-one hundred seventy-four of this chapter.

3. The commissioner may release information collected through the statewide perinatal data system to his or her designees, including persons or entities under contract with the department to review quality of care issues, as required to monitor regional perinatal centers and affiliate hospitals and conduct quality improvement initiatives as needed to monitor, evaluate and improve patient care and outcomes. Such designee or person or entity under contract with the department to review quality of care issues shall maintain the confidentiality of all such information and shall use it only to improve quality of care, as approved by the department.

* NB There are 2 § 2500-h's

*** § 2500-h. Anaphylactic policy for school districts and child care providers.** 1. (a) The commissioner, in consultation with the commissioner of education, shall establish an anaphylactic policy for school districts setting forth guidelines and procedures to be followed for both the prevention of anaphylaxis and during a medical emergency

resulting from anaphylaxis. Such policy shall be developed after consultation with representatives of pediatric physicians, school nurses and other health care providers with expertise in treating children with anaphylaxis, parents of children with life threatening allergies, school administrators, teachers, school food service directors and appropriate not-for-profit corporations representing allergic individuals at risk for anaphylaxis.

(b) The commissioner, in consultation with the commissioner of children and family services, shall establish an anaphylactic policy for child day care providers as defined in section three hundred ninety of the social services law setting forth guidelines and procedures to be followed for both the prevention of anaphylaxis and during a medical emergency resulting from anaphylaxis. Such policy shall be developed after consultation with representatives of pediatric physicians and other health care providers with expertise in treating children with anaphylaxis, parents of children with life threatening allergies, child day care administrators and personnel, and appropriate not-for-profit corporations representing allergic individuals at risk for anaphylaxis. The commissioner, in consultation with the commissioner of children and family services, shall create informational materials detailing such anaphylactic policies to be distributed to child day care centers.

(c) In establishing policies pursuant to this subdivision, such commissioners shall consider existing requirements, as well as current and best practices for schools and child day care providers on allergies and anaphylaxis, including those in place for child care centers regulated by the New York city department of health and mental hygiene. Such commissioners shall also consider the voluntary guidelines for managing food allergies in schools and early care and education programs issued by the United States department of health and human services, to the extent appropriate for the setting.

(d) The commissioner shall create informational materials detailing such anaphylactic policies to be distributed to local school boards of education, charter schools, boards of cooperative educational services, and child day care centers, and shall make the materials available on the department's website.

2. The anaphylactic policies established under subdivision one of this

section shall include the following:

(a) a procedure and treatment plan, including emergency protocols and responsibilities for school nurses and other appropriate school and child day care personnel, for responding to anaphylaxis;

(b) a training course for appropriate school and child day care personnel for preventing and responding to anaphylaxis. The commissioner shall, in consultation with the commissioner of children and family services and the commissioner of education, consider existing training programs for responding to anaphylaxis in order to avoid duplicative training requirements. Such pre-existing program shall fulfill the requirement for a training course pursuant to this subdivision if the standards of such pre-existing program are deemed by the commissioner to be at least as stringent as the standards promulgated by the commissioner in the development of the training course by the state;

(c) a procedure and appropriate guidelines for the development of an individualized emergency health care plan for children with a food or other allergy which could result in anaphylaxis;

(d) a communication plan for intake and dissemination of information provided by the state regarding children with a food or other allergy which could result in anaphylaxis, including a discussion of methods, treatments and therapies to reduce the risk of allergic reactions, including anaphylaxis;

(e) strategies for the reduction of the risk of exposure to anaphylactic causative agents, including food and other allergens; and

(f) a communication plan for discussion with children that have developed adequate verbal communication and comprehension skills and with the parents or guardians of all children about foods that are safe and unsafe and about strategies to avoid exposure to unsafe food.

3. At least once per calendar year, schools shall send a notification to the parents and/or guardians of all children under the care of such schools to make them aware of such anaphylactic policies, as developed by the commissioner. For children under the care of the child day care providers, such notification shall be provided by the child day care provider when the child is enrolled and annually thereafter. Such notifications shall include contact information for parents and guardians to engage further with the school or child day care provider

to learn more about individualized aspects of such policies.

4. Within six months of the effective date of the chapter of the laws of two thousand nineteen which amended this section, the anaphylactic policies established under this section shall be jointly forwarded by the commissioner as well as the commissioner of education or the commissioner of children and family services as appropriate to each local school board of education, charter school, board of cooperative educational services and child day care service provider, as defined in section three hundred ninety of the social services law, in the state. Each such entity shall implement or update as appropriate their anaphylactic policy in accordance with those developed by the state within six months of receiving the anaphylactic policies.

5. The anaphylactic policies established by this section shall be updated at least once every three years, or more frequently if the commissioner determines it to be necessary or desirable for the protection of children with a food allergy or other allergy which could result in anaphylaxis.

* NB There are 2 § 2500-h's

§ 2500-i. Child food choking prevention. 1. The department shall establish criteria for determining which foods and food products may pose a significant choking risk for children in various age groups.

2. The department shall conduct an ongoing public awareness and education program under section two hundred seven of this chapter on choking risks, precautions and life-saving procedures, including, but not limited to, listing on its internet website information that assists members of the public in locating infant and child cardiopulmonary resuscitation classes.

3. The department shall produce and distribute educational materials on food choking risks, precautions and life-saving procedures. Such materials shall be made available to child care centers, pediatricians and nursery, elementary and secondary schools for distribution to

persons in parental relation to children, and to hospitals, birthing centers and other appropriate health care providers for distribution to maternity patients. In addition, such materials shall be provided to health care professionals engaged in the care and treatment of children for distribution to such children and persons in parental relation. The department shall also provide information on food choking risks, precautions and life-saving procedures on the department's internet website. No provision of this subdivision shall be deemed to prohibit the utilization and distribution of educational materials relating thereto produced by any public, private or governmental entity, in lieu of the department's production of such materials.

4. The department shall periodically review available data on choking incidents in children and update the information on choking risks, precautionary measures and life-saving procedures provided in its educational materials and on its internet website, as appropriate.

5. The department shall report every three years, commencing January first, two thousand eighteen, to the governor, the temporary president of the senate and the speaker of the assembly on the implementation of this section and any recommendations for furthering the purpose of this section.

6. Implementation of this section shall be contingent upon and shall be conducted within appropriations made therefor.

§ 2500-j. Autism spectrum disorders; screening of children. 1. The commissioner shall establish, for use by pediatric primary care providers, best practice protocols for early screening of children for autism spectrum disorders, including but not limited to developmental screening for children three years of age and under. Such protocols shall incorporate standards and guidelines established by the American Academy of Pediatrics, shall be updated at least biennially, and shall include, but not be limited to:

(a) the routine employment of objective autism spectrum disorder screening tools at regular intervals during critical childhood

developmental stages;

(b) a provider/parental dialogue, utilizing the modified checklist for autism in toddlers as a reference, intended to educate parents in regard to autism spectrum disorders; and

(c) an appropriate referral mechanism for children who, based upon results of the aforementioned screening process, require further evaluation.

2. The modified checklist for autism in toddlers referred to in subdivision one of this section shall be accessible by the public on the department's internet website.

3. The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this section.

§ 2500-k. Maternal depression. 1. Definitions. As used in this section:

(a) "Maternal depression" means a wide range of emotional and psychological reactions an individual may experience throughout pregnancy and the postpartum period. These reactions may include, but are not limited to, feelings of despair or extreme guilt, prolonged sadness, lack of energy, difficulty concentrating, fatigue, extreme changes in appetite, and thoughts of suicide or of harming the baby. Maternal depression may include prenatal depression, perinatal mood and anxiety disorder, the "baby blues," postpartum depression, or postpartum psychosis.

(b) "Maternal health care provider" means a physician, midwife, nurse practitioner, or physician assistant, or other health care practitioner acting within his or her lawful scope of practice, attending a perinatal individual, including any practitioner attending the individual's child, from conception up to one year postpartum.

2. Maternal depression information. (a) The commissioner, in consultation with the commissioner of mental health, shall make available to maternal health care providers information on maternal depression. The information shall include, but not be limited to:

(i) a summary of the current evidence base and professional guidelines for maternal depression screening;

(ii) validated, evidence-based tools for maternal depression screening;

(iii) information about follow-up support for patients who may require further evaluation, referral, or treatment including, when available, information about specific community resources and entities licensed by the office of mental health; and

(iv) information on engaging support for the mother, which may include communicating with the other parent of the child and other family members, as appropriate and consistent with patient confidentiality.

(b) The information on maternal depression shall be posted on the department's website. The commissioner shall, in collaboration with the commissioner of mental health, update and review the information on maternal depression, as necessary.

3. Maternal depression screenings. (a) The commissioner, in consultation with the office of mental health, the office of addiction services and supports, and other relevant stakeholders as determined by the commissioner, shall publish guidance for incorporating maternal depression screenings into routine perinatal care. This guidance shall include, but not be limited to, recommendations and best practices related to:

(i) when maternal health care providers should initiate maternal depression screenings and how often such screenings should be repeated throughout pregnancy and the postpartum period;

(ii) screening for social needs that may contribute to maternal depression such as social support, intimate partner violence, food and housing insecurity, diaper insecurity, and barriers to appropriate healthcare;

(iii) screening for substance use disorders;

(iv) referrals for appropriate follow-up evaluation, diagnosis, and treatment; and

(v) reimbursement methodologies to incentivize provider participation.

(b) The commissioner, in consultation with the office of mental health, the office of addiction services and supports, and other relevant stakeholders as determined by the commissioner, shall identify

existing information and training programs designed to inform providers in an effort to promote maternal depression screening and treatment, and publish the links to such information and training programs on the department's website. The identified information and training programs shall include the following topics:

- (i) health equity;
- (ii) implicit bias and cultural competency;
- (iii) screening, referral and treatment options;
- (iv) patient resources and available services;
- (v) patients' rights;
- (vi) pharmacotherapy;
- (vii) trauma-informed, patient-centered care; and
- (viii) other topics as identified by the commissioner.

4. Maternal depression treatment. The commissioner, in consultation with the commissioner of mental health, shall:

(a) inform providers of the need to raise awareness about maternal depression; and

(b) provide information on the department's and office of mental health's websites regarding how to locate available providers who treat or provide support for maternal depression including, but not limited to, mental health professionals, other licensed professionals, peer support, not-for-profit corporations and other community resources.

5. The commissioner shall make any regulations necessary to implement this section.

§ 2500-1. Pregnant people, blood test for hepatitis C virus (HCV); follow-up care. 1. Every physician or other authorized practitioner attending a pregnant person in the state shall order a hepatitis C virus (HCV) screening test and if the test is reactive, an HCV RNA test must be performed on the same specimen, or a second specimen collected at the same time as the initial HCV screening test specimen, to confirm diagnosis of current infection. The health care provider shall either offer all persons with a detectable HCV RNA test follow-up HCV health care and treatment or refer the individual to a health care provider who

can provide follow-up HCV health care and treatment.

2. The physician or other authorized practitioner attending a pregnant person shall record the HCV test results prominently in the pregnant person's medical record at or before the time of hospital admission for delivery.

3. The commissioner may promulgate such rules and regulations as are necessary to carry out the requirements of this section.

§ 2500-m. Access to doulas. (a) When a person is admitted to a maternal health care facility for delivery and/or inpatient care post-delivery, such person may designate a doula to have access to such person. The maternal health care facility shall not deny such person access to such person's designated doula. For the purposes of this section, the term "maternal health care facility" shall mean a hospital or freestanding birthing center providing perinatal services in accordance with article twenty-eight of this chapter and applicable regulations.

(b) Nothing in this section shall require a maternal health care facility to grant a doula access to a person or area of the facility during emergencies or when such access could compromise the safety of the patient or health care team.

(c) The department shall require all maternal health care facilities to include and/or post on the maternal health care facility's webpage, lobby, and patient waiting areas information stating a birthing parent is allowed to have a doula present in the maternal health care facility for delivery and/or inpatient care post-delivery. Such information shall be written in layperson's language and shall be made available in English and the six most common non-English languages spoken by individuals with limited English proficiency in New York state as based on the most recent census. The department shall produce and provide maternal health care facilities with informational pamphlets stating a birthing parent shall be allowed to have a doula present in the maternal health care facility for delivery and/or inpatient care post-delivery. The informational pamphlet shall be: available in each patient waiting

area as a printed deliverable; written in layperson's language; and made available in English and the six most common non-English languages spoken by individuals with limited English proficiency in New York state as based on the most recent census.

§ 2501. Health and welfare services to all children; duty of local boards. 1. The local board of health or similar health authority of each local health district shall provide children who attend schools other than public with all or any of the health and welfare services and facilities, including but not limited to health, surgical, medical, dental and therapeutic care and treatment and corrective aids and appliances, authorized by law and now granted or hereafter made available by such local board of health or similar health authority for or to children in the public schools in so far as these services and facilities may be requested by the authorities of the schools other than public.

2. Any services or facilities provided pursuant to the provisions of this section shall be so provided notwithstanding any provision of any charter or other provision of law inconsistent herewith.

§ 2502. Report of certain conditions. Any nurse-midwife, nurse or other person having the care of an infant within the age of two weeks who neglects or omits to report immediately to the health officer or to a legally qualified practitioner of medicine of the city, town or place where such child is being cared for, the fact that one or both eyes of such infant are inflamed or reddened whenever such shall be the case, or who applies any remedy therefor without the advice, or except by the direction of such officer or physician is guilty of a misdemeanor.

§ 2503. Drug information to be furnished expectant mothers. The physician or nurse-midwife to be in attendance at the birth of a child shall inform the expectant mother, in advance of the birth, of the drugs that such physician or nurse-midwife expects to employ during pregnancy

and of the obstetrical and other drugs that such physician or nurse-midwife expects to employ at birth and of the possible effects of such drugs on the child and mother.

§ 2504. Enabling certain persons to consent for certain medical, dental, health and hospital services. 1. Any person who is eighteen years of age or older, or is the parent of a child or has married, or is a homeless youth as defined in section five hundred thirty-two-a of the executive law, or receives services at an approved runaway and homeless youth crisis services program or a transitional independent living support program as defined in section five hundred thirty-two-a of the executive law, may give effective consent for medical, dental, health and hospital services, including behavioral health services, for themselves, and the consent of no other person shall be necessary.

2. Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child. Any person who has been designated pursuant to title fifteen-A of article five of the general obligations law as a person in parental relation to a child may consent to any medical, dental, health and hospital services for such child for which consent is otherwise required which are not: (a) major medical treatment as defined in subdivision (a) of section 80.03 of the mental hygiene law; (b) electroconvulsive therapy; or (c) the withdrawal or discontinuance of medical treatment which is sustaining life functions.

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

4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent, legal guardian or person possessing a lawful order of custody when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.

5. Where not otherwise already authorized by law to do so, any person in a parental relation to a child as defined in section twenty-one hundred sixty-four of this chapter and, (i) a grandparent, an adult brother or sister, an adult aunt or uncle, any of whom has assumed care of the child and, (ii) an adult who has care of the child and has written authorization to consent from a person in a parental relation to a child as defined in section twenty-one hundred sixty-four of this chapter, may give effective consent for the immunization of a child. However, a person other than one in a parental relation to the child shall not give consent under this subdivision if he or she has reason to believe that a person in parental relation to the child as defined in section twenty-one hundred sixty-four of this chapter objects to the immunization.

6. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent.

7. No person shall perform a pelvic examination or supervise the performance of a pelvic examination on an anesthetized or unconscious patient unless the person performing the pelvic examination is legally authorized to do so and the person supervising the performance of the pelvic examination is legally authorized to do so and:

(a) the patient or the patient's authorized representative gives prior oral or written informed consent specific to the pelvic examination;

(b) the performance of a pelvic examination is within the scope of care for the surgical procedure or diagnostic examination scheduled to be performed on the patient and to which the patient has already given oral or written consent; or

(c) the patient is unconscious and the pelvic examination is medically necessary for diagnostic or treatment purposes, and the patient is in immediate need of medical attention and an attempt to secure consent would result in a delay of treatment which would increase the risk to the patient's life or health.

Nothing in this subdivision diminishes any other requirement to obtain

informed consent for a pelvic examination or any other procedure.

§ 2504-a. Hepatitis B immunization of a minor. 1. A health care practitioner may administer immunization against hepatitis B to a person under the age of eighteen years without the consent or knowledge of the parents or guardian of said person, if said person has capacity to consent and consents to the immunization, and said person is housed in a state or local correctional facility.

2. For the purposes of this section:

(a) the term "health care practitioner" shall mean a person licensed, certified or otherwise authorized to practice under title eight of the education law, acting within his or her lawful scope of practice; and

(b) the term "capacity to consent" shall mean an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of the proposed immunization, and to make an informed decision concerning the immunization.

§ 2504-b. Information concerning pelvic exams. 1. On or before July first, two thousand twenty-two, the department shall develop an informational pamphlet for patients undergoing pelvic examinations. In developing the pamphlet, the department shall consult with state professional societies representing physicians in general, obstetricians and gynecologists, family practice physicians, nurse practitioners, physician assistants and midwives. The pamphlet shall include but not be limited to information concerning, the following:

(a) what a pelvic exam is and how it is properly performed;

(b) if applicable, a description of other relevant exams;

(c) privacy expectations, including that privacy should be provided for the patient both when undressing and dressing and that a gown or a drape should be provided;

(d) an explanation of what a speculum is and how it should be properly used during an examination;

(e) that gloves should be worn by the practitioner during the examination; and

(f) a telephone number for the office of professional medical conduct in the department and the office of the professions in the state education department, at which a patient may report any misconduct that the patient feels may have occurred.

2. The informational pamphlet shall be made available for use by practitioners. The informational pamphlet shall be posted as a printable file on the department's internet website, and may also be made available for order as a printed deliverable on the department's internet website.

3. The informational pamphlet shall be written in layperson's language and shall be made available in English and the six most common non-English languages spoken by individuals with limited English proficiency in New York state as based on the most recent census.

4. A practitioner may provide the patient the informational pamphlet developed pursuant to this section.

5. For purposes of this section, "practitioner" means a health care professional licensed, certified, or otherwise authorized to practice under the education law, acting within the scope of practice.

§ 2505. Human breast milk; collection, storage and distribution; general powers of the commissioner. The commissioner is hereby empowered to:

(a) adopt regulations and guidelines including, but not limited to donor standards, methods of collection, and standards for storage, and distribution of human breast milk;

(b) conduct educational activities to inform the public and health care providers of the availability of human breast milk for infants determined to require such milk and to inform potential donors of the opportunities for proper donation;

(c) conduct educational activities to encourage and facilitate employers and child day care centers to establish environments that do not discourage breastfeeding and the provision of breast milk. Such

environments may include sanitary locations for breastfeeding and refrigerators to assist in breastfeeding and feeding babies with expressed breast milk; and

(d) establish rules and regulations to effectuate the provisions of this section.

§ 2505-a. Rights of breastfeeding mothers. 1. The principles enunciated in subdivision three of this section are declared to be the public policy of the state and a copy of such statement of rights shall be posted conspicuously in a public place in each maternal health care facility and child day care facility. For purposes of this section, "maternal health care provider" means a physician, midwife, or other authorized practitioner attending a pregnant woman; and "maternal health care facility" includes hospitals and freestanding birthing centers providing perinatal services in accordance with article twenty-eight of this chapter and applicable regulations.

2. The commissioner shall make available to every maternal health care provider, maternal health care facility and child day care facility, on the health department's website for the purpose of health care facilities to include such rights in the maternity information leaflet as described in section twenty-eight hundred three-j of this chapter, a copy of the statement of rights provided in subdivision three of this section in the top six languages other than English spoken in the state according to the latest available data from the U.S. Bureau of Census, and shall adopt any rules and regulations necessary to ensure that such patients are treated in accordance with the provisions of such statement.

3. The statement of rights shall consist of the following:

"Breastfeeding Mothers' Bill of Rights"

Choosing the way you will feed your new baby is one of the important decisions you will make in preparing for your infant's arrival. Doctors agree that for most women breastfeeding is the safest and most healthy choice. It is your right to be informed about the benefits of

breastfeeding and have your health care provider, maternal health care facility and child day care facility encourage and support breastfeeding. You have the right to make your own choice about breastfeeding. Whether you choose to breastfeed or not you have the following basic rights regardless of your race, creed, national origin, sexual orientation, gender identity or expression, or source of payment for your health care. Maternal health care facilities have a responsibility to ensure that you understand these rights. They must provide this information clearly for you and must provide an interpreter if necessary. These rights may only be limited in cases where your health or the health of your baby requires it. If any of the following things are not medically right for you or your baby, you should be fully informed of the facts and be consulted.

(1) Before You Deliver, if you attend prenatal childbirth education classes provided by the maternal health care facility and all hospital clinics and diagnostic and treatment centers providing prenatal services in accordance with article 28 of the public health law you must receive the breastfeeding mothers' bill of rights. Each maternal health care facility shall provide the maternity information leaflet, including the Breastfeeding Mothers' Bill of Rights, in accordance with section twenty-eight hundred three-i of the public health law to each patient or to the appointed personal representative at the time of prebooking or time of admission to a maternal health care facility. Each maternal health care provider shall give a copy of the Breastfeeding Mothers' Bill of Rights to each patient at or prior to the medically appropriate time.

You have the right to complete information about the benefits of breastfeeding for yourself and your baby. This will help you make an informed choice on how to feed your baby.

You have the right to receive information that is free of commercial interests and includes:

- * How breastfeeding benefits you and your baby nutritionally, medically and emotionally;
- * How to prepare yourself for breastfeeding;
- * How to understand some of the problems you may face and how to solve

them.

(2) In The Maternal Health Care Facility:

- * You have the right to have your baby stay with you right after birth whether you deliver vaginally or by cesarean section. You have the right to begin breastfeeding within one hour after birth.

- * You have the right to have someone trained to help you in breastfeeding give you information and help you when you need it.

- * You have the right to have your baby not receive any bottle feeding or pacifiers.

- * You have the right to know about and refuse any drugs that may dry up your milk.

- * You have the right to have your baby in your room with you 24 hours a day.

- * You have the right to breastfeed your baby at any time day or night.

- * You have the right to know if your doctor or your baby's pediatrician is advising against breastfeeding before any feeding decisions are made.

- * You have the right to have a sign on your baby's crib clearly stating that your baby is breastfeeding and that no bottle feeding of any type is to be offered.

- * You have the right to receive full information about how you are doing with breastfeeding and get help on how to improve.

- * You have the right to breastfeed your baby in the neonatal intensive care unit. If nursing is not possible, every attempt will be made to have your baby receive your pumped or expressed milk.

- * If you, or your baby, are re-hospitalized in a maternal care facility after the initial delivery stay, the hospital will make every effort to continue to support breastfeeding, to provide hospital grade electric pumps and rooming in facilities.

- * You have the right to have help from someone specially trained in breastfeeding support and expressing breast milk if your baby has special needs.

- * You have the right to have a family member or friend receive breastfeeding information from a staff member if you request it.

(3) When You Leave The Maternal Health Care Facility:

- * You have the right to printed breastfeeding information free of commercial material.

* You have the right, unless specifically requested by you, and available at the facility, to be discharged from the facility without discharge packs containing infant formula, or formula coupons unless ordered by your baby's health care provider.

* You have the right to get information about breastfeeding resources in your community including information on availability of breastfeeding consultants, support groups and breast pumps.

* You have the right to have the facility give you information to help choose a medical provider for your baby and understand the importance of a follow-up appointment.

* You have the right to receive information about safely collecting and storing your breast milk.

* You have the right to breastfeed your baby in any location, public or private, where you are otherwise authorized to be. Complaints can be directed to the New York State Division of Human Rights.

* You have a right to breastfeed your baby at your place of employment or child day care center in an environment that does not discourage breastfeeding or the provision of breast milk.

* You have the right to take reasonable unpaid breaks at work so you can pump breast milk for up to three years following childbirth under section 206-c of the Labor Law. Your employer must make reasonable efforts to provide a room or other locations where you can express breast milk in privacy. Your employer may not discriminate against you based on your decision to express breast milk at work. Complaints can be directed to the New York State Department of Labor.

All the above are your rights. If the maternal health care facility does not honor these rights you can seek help by contacting the New York state department of health or by contacting the hospital complaint hotline or via email.

4. The commissioner shall make regulations reasonably necessary to implement this section.

§ 2505-b. Lactation accommodations in airports. 1. The terminal operator of a commercial service airport owned or operated by a county,

city, town, village, or state or local authority that has one million or more enplanements a year shall provide a room or other location at each airport passenger terminal behind the airport security screening area for members of the public to express breast milk in private that meets the following conditions:

- (a) includes, at a minimum, a chair and an electrical outlet;
- (b) is located outside of the confines of a public restroom; and
- (c) upon completion of the construction of a new passenger terminal, or the replacement, expansion, or renovation of an existing passenger terminal, includes a sink.

2. The terminal operator of a commercial service airport owned or operated by a county, city, town, village, or state or local authority that has fewer than one million, but more than ten thousand enplanements a year shall, upon completion of the construction of a new passenger terminal, or the replacement, expansion, or renovation of an existing passenger terminal, provide a room or other location at each airport passenger terminal behind the airport security screening area for members of the public to express breast milk in private that meets the following conditions:

- (a) includes, at a minimum, a chair, a sink, and an electrical outlet; and
- (b) is located outside of the confines of a public restroom.

3. As used in this section, "renovation of an existing passenger terminal" means the repurposing of more than twenty-five percent of the space in the passenger terminal.

§ 2506. Obstetric and pediatric practitioner incentive demonstration program. 1. There is hereby established in the department the obstetric and pediatric practitioner incentive demonstration program, to provide financial support for obstetric practitioners providing prenatal and obstetric services to medically needy women and to pediatric practitioners serving children up to one year of age, to assist them in paying for professional liability insurance coverage related to those services, within amounts appropriated for that purpose.

2. As used in this section, the following terms shall have the following meanings:

(a) "Obstetric practitioner". A physician who is board certified or an active candidate for board certification in obstetrics, a physician who is board certified, or eligible for board certification, in family practice and provides obstetric services, a certified nurse midwife, or an obstetric nurse practitioner.

(b) "Pediatric practitioner". A physician who is board certified, or eligible for board certification, in pediatrics or a pediatric nurse practitioner.

(c) "Prenatal and obstetric services to medically needy women" and "pediatric services for children up to one year of age". Prenatal and obstetric services provided by an obstetric practitioner, and pediatric services for children up to one year of age, in private individual or group practice, or comprehensive diagnostic and treatment centers pursuant to article twenty-eight of this chapter, to women and children (i) through the prenatal care assistance program, or the medical assistance program under the social services law; or (ii) through a program approved by the commissioner under this section, under which the services are provided without remuneration to the practitioner for his or her services; or (iii) who are not covered for these services by subparagraph (i) of this paragraph or by private health insurance.

3. The commissioner is authorized to contract with obstetric and pediatric practitioners to provide financial support for the costs they bear for their professional liability insurance coverage, to the extent that the cost is reasonably related or proportional to the amount of prenatal and obstetric and pediatric services to medically needy women and children up to one year of age the practitioner provides in proportion to the total amount of prenatal, obstetric and pediatric services the practitioner provides.

4. Prenatal and obstetric services and pediatric services for children up to one year of age provided without remuneration to the obstetrical or pediatric practitioner, for the purposes of this section, shall be provided as part of a program administered by a general hospital (as

defined in article twenty-eight of this chapter) or a city or county health department, approved by the commissioner.

5. The commissioner shall establish regulations, standards and procedures for the obstetric and pediatric practitioner incentive demonstration program, including but not limited to quality assurance, the services to be provided, and the provision of records and information by obstetric and pediatric practitioners applying for or receiving support under this section.

6. In making contracts under this section, the commissioner shall consider the extent to which the support will increase, maintain and improve the accessibility and quality of prenatal and obstetric services to medically needy women and pediatric services to children up to one year of age, and shall assure that support is reasonably distributed geographically throughout urban and rural areas of the state.

7. On or before February first, nineteen hundred ninety-two, the commissioner shall submit to the governor and the chairs of the assembly and senate committees on health a report on the operation and effectiveness of the obstetric and pediatric practitioner incentive demonstration program, including any recommendations the commissioner deems appropriate.

§ 2507. Special supplemental nutrition program for women, infants and children; specialty formula.

1. Definitions. For the purposes of this section:

(a) "WIC" shall mean the special supplemental nutrition program for women, infants and children;

(b) "WIC food vendor" shall mean a business entity that operates a retail delivery system that is authorized by the department to sell products covered by WIC to individuals under the WIC program; and

(c) "Specialty formula" shall mean specifically formulated nutrition products prescribed for medically fragile WIC participants with qualifying medical conditions.

2. Every WIC food vendor shall be authorized to sell any product covered under WIC, including specialty formula, in accordance with the WIC vendor type as designated by the department, unless specifically limited or barred by the commissioner pursuant to state or federal regulations. The commissioner is authorized to establish criteria defining which WIC food vendors can sell specialty formula. Any such criteria shall not be applied arbitrarily and shall ensure WIC participant access to specialty formula. The commissioner shall establish a process to address individual cases where there is evidence of inadequate WIC participant access.

§ 2508. Newborn health and safe sleep study. There shall be established in the department, by the commissioner, a newborn health and safe sleep study designed to reduce infant mortality rates across the state and enhance existing strategies to improve safe sleep practices. The department, in consultation with health care providers, hospitals, safe sleep product manufacturers, provider groups, the New York state office of children and family services, and any other person or entity the commissioner deems necessary, shall conduct a study on the effectiveness of existing safe sleep practices and identify additional safe sleep practices that reduce infant mortality rates. The study shall include a review of baby boxes and other products aimed at encouraging safe and healthy sleep practices. The department shall report to the legislature within twelve months of the effective date of this section on the results of this study. Within twelve months after the completion of the study, the department shall conduct a pilot program aimed at improving caregiver education and continued safe sleep practices in counties or areas with high infant mortality rates, and also shall pursue available funding options and make efforts to establish a public-private partnership with organizations that promote such causes or manufacture such products in order to seek to obtain donations for these purposes.

§ 2509. Maternal mortality review board. 1. (a) There is hereby

established in the department the maternal mortality review board for the purpose of reviewing maternal deaths and maternal morbidity and developing and disseminating findings, recommendations, and best practices to contribute to the prevention of maternal mortality and morbidity. The board shall assess the cause of death, factors leading to death and preventability for each maternal death reviewed and, in the discretion of the board, cases of severe maternal morbidity, and shall develop and disseminate strategies for reducing the risk of maternal mortality and morbidity, including risk resulting from racial, economic, or other disparities. The commissioner may delegate the authority to conduct maternal mortality reviews.

(b) The commissioner may enter into an agreement with the city of New York providing:

(i) that the functions of the state board relating to maternal deaths and severe maternal morbidity occurring within the city of New York shall be conducted by the city board;

(ii) the city board shall provide to the state board the results of its reviews, relevant information in the possession of the city board, and the recommendations of the city board; and

(iii) the department and the state board shall provide information and assistance to the city board for the performance of its functions.

(c) Nothing in this section shall prevent the city of New York from establishing, without an agreement with the commissioner, a board relating to maternal deaths and severe maternal morbidity occurring within the city of New York.

2. As used in this section, unless the context requires otherwise:

(a) "Advisory council" and "council" mean the advisory council on maternal mortality and morbidity, established under this section.

(b) "Board" means a maternal mortality review board established by this section, referred to in this section as the "state board", or a board operating under this section established by the city of New York, with or without an agreement with the commissioner, referred to in this section as the "city board".

(c) "Maternal death" means the death of a woman during pregnancy or within a year from the end of pregnancy.

(d) "Severe maternal morbidity" or "morbidity" means unexpected

outcomes of pregnancy, labor, or delivery that result in significant short- or long-term consequences to a woman's health.

(e) "City commissioner" means the commissioner of the New York city department of health and mental hygiene.

3. (a) The members of the state board shall be comprised of multidisciplinary experts in the field of maternal mortality, women's health and public health, and shall include health care professionals or other experts who serve and are representative of the racial, ethnic, and socioeconomic diversity of the women and mothers of the state and, to the extent possible, the medically underserved areas of the state or areas of the state with disproportionately high occurrences of maternal mortality or morbidity.

(b) The state board shall be composed of at least fifteen members, all of whom shall be appointed by the commissioner.

(c) The terms of the state board members shall be three years. The commissioner may choose to reappoint state board members to additional three year terms.

(d) A majority of the appointed membership of the state board, no less than three, shall constitute a quorum.

(e) When any member of the state board fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the state board shall be held at least twice a year but may be held more frequently as deemed necessary, subject to request of the department.

(g) Members of the state and city boards shall be indemnified under section seventeen of the public officers law or section fifty-k of the general municipal law, as the case may be.

(h) Members of the state board shall not be compensated for their participation on the board but shall receive reimbursement for their ordinary and necessary expenses of participation.

(i) Membership on a board shall not disqualify any person from holding any public office or employment.

4. (a) The commissioner may request and shall receive upon request

from any department, division, board, bureau, commission, local health departments or other agency of the state or political subdivision thereof or any public authority, such information, including but not limited to death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records and any other information that will help the department under this section to properly carry out its functions, powers and duties. The commissioner, or the city commissioner for the maternal deaths or maternal morbidity occurring within the vital statistics registration district of the city of New York may request and shall receive upon request from any department, division, board, commission or other agency under the authority of the city of New York as well as hospitals established pursuant to article twenty-eight of this chapter, birthing facilities, medical examiners, coroners and coroner physicians and any other facility providing services associated with maternal mortality or maternal morbidity, such information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records and any other information that will help the department under this section to properly carry out its functions, powers and duties.

(b) The commissioner and the city commissioner shall receive and may solicit voluntary information, including oral or written statements, relating to any maternal death and case of severe maternal morbidity, from any family member or other interested party (including the patient in a case of severe maternal morbidity) relating to any case that may come before the board. Oral statements received under this paragraph shall be transcribed or summarized in writing. The commissioner and the city commissioner shall transmit that information to the board considering the case.

(c) Before transmitting any information to the board, the commissioner or the city commissioner shall remove all personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well as the hospital or facility that treated the woman, and any other information such as geographic location that may inadvertently identify the woman, practitioner or facility. This paragraph shall not preclude the transmitting of information to the board that is reasonably necessary to

enable the board to perform an appropriate review under this section.

5. Each board:

(a) shall make and report findings and recommendations to the commissioner, and in the case of the city board to the commissioner and the city commissioner regarding the cause of death, factors leading to death, and preventability of each maternal death case, and each case of severe maternal morbidity reviewed by the board, by reviewing relevant information for each case in the state or the city of New York, as the case may be, and consulting with experts as needed to evaluate the information for each death; and shall provide such findings and recommendations, including best practices and strategies for reducing the risk of maternal mortality and morbidity, to the advisory council; provided that material provided to the advisory council shall not include any information that would be confidential under this section;

(b) shall develop recommendations to the commissioner, and in the case of the city board to the commissioner and the city commissioner for areas of focus, including issues of severe maternal morbidity and issues of racial, economic or other disparities in maternal outcomes;

(c) may, in addition to the findings and recommendations made under this subdivision, and consistent with all applicable confidentiality protections, bring any particular matter to the attention of the commissioner or the city commissioner, and in the case of the city board to the commissioner and the city commissioner;

(d) shall issue a report on its findings and recommendations every two years, and may also issue reports more frequently. The reports shall be public documents; and

(e) may request and shall receive the assistance of the commissioner in the instance of the state board and the city commissioner in the instance of the city board in carrying out its functions.

6. The commissioner and the city commissioner and the state and city boards shall each keep confidential any information collected or received under this section that includes personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well as the hospital or facility that treated the woman, and any other information

such as geographic location that may inadvertently identify the woman, practitioner or facility, and shall use the information provided or received under this section solely for the purposes of improvement of the quality of health care of women and to prevent maternal mortality and morbidity. This subdivision shall not preclude the transmitting of information to the board that is reasonably necessary to enable the board to perform an appropriate review under this section. All records received, meetings conducted, reports, except those reports required to be issued by the board by this section, and records made and maintained and all books and papers obtained by the board shall be confidential and shall not be made open or available, including under article six of the public officers law, and shall be limited to board members as well as those authorized by the commissioner or city commissioner. Such information shall not be discoverable or admissible as evidence in any action in any court or before any other tribunal, board, agency or person.

7. The commissioner and the city commissioner, within their respective legal authority, may use the recommendations and findings of the boards to develop guidance and other actions relating to best practices, and shall disseminate information relating to that guidance and other actions to appropriate health care providers.

8. (a) There is hereby established in the department an advisory council on maternal mortality and morbidity.

(b) The advisory council:

(i) may review the findings of the boards;

(ii) may develop recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity;

(iii) may hold public hearings on those matters;

(iv) may make findings and issue reports, including an annual report, on such matters; and

(v) may request and shall receive the assistance of the commissioner, the city commissioner, and the boards in carrying out its functions.

(c) The advisory council shall consist of at least twenty members to be determined by the commissioner. The commissioner shall appoint the members of the council, at least ten of whom shall be on the

recommendation of the city commissioner. The commissioner shall appoint the chair of the council.

(d) The members of the council shall be comprised of multidisciplinary experts and lay persons knowledgeable in the field of maternal mortality, women's health and public health and shall include members who serve and are representative of the racial, ethnic, and socioeconomic diversity of the women and mothers of the state, and to the extent possible, the medically underserved areas of the state or areas of the state with disproportionately high occurrences of maternal mortality or morbidity.

(e) The terms of the council members shall be three years. The commissioner may choose to reappoint council members to additional three-year terms. Vacancies on the council shall be filled by appointment by the commissioner, consistent with paragraph (c) of this subdivision. A majority of the appointed membership of the council shall constitute a quorum. When any member of the council fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the council shall be held at least twice a year.

(g) Members of the council shall be indemnified under section seventeen of the public officers law. Members of the council shall not be compensated for their participation on the council but shall receive reimbursement for their ordinary and necessary expenses of participation. Membership on the council shall not disqualify any person from holding any public office or employment.

§ 2509-a. Corded window blind leaflet. The commissioner, in consultation with the secretary of state, shall create a leaflet regarding the danger that corded window blinds pose to children including proper installation of blinds, examples of current standards and the potential fatal consequences from strangulation posed by corded window blinds. Such leaflet shall be posted on the department's website in a printable format to allow each pediatric primary care provider to provide the leaflet to parents at a child's six month well child visit.

§ 2509-c. Availability of adverse childhood experiences services.

Every pediatrics health care provider licensed pursuant to article one hundred thirty-one of the education law shall be required to provide the parent, guardian, custodian or other authorized individual of a child that the pediatrician sees in their official capacity, with educational materials developed pursuant to subdivision two of section three hundred seventy-c of the social services law. Such materials may be provided electronically and shall be used to inform and educate them about adverse childhood experiences, the importance of protective factors and the availability of services for children at risk for or experiencing adverse childhood experiences.

§ 2509-d. Veterans reproductive mental health care. 1. As used in this section:

(a) "Maternal health care provider" means a physician, midwife, nurse practitioner, physician assistant, or other health care practitioner acting within their lawful scope of practice, attending a pregnant veteran or a veteran up to one year after childbirth, including a practitioner attending the veteran's child up to one year after childbirth.

(b) "Women veterans coordinator" shall mean the women veterans coordinator appointed pursuant to section nineteen of the veterans' services law.

(c) "Veteran" shall have the same meaning as such term is defined in section one of the veterans' services law and shall also include a veteran who has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service.

2. (a) The commissioner, in consultation with the commissioner of mental health and the women veterans coordinator, shall make available to maternal health care providers information on veterans reproductive

mental health care. The information shall include, but not be limited to:

- (i) the importance of identifying whether a patient has served in the military in providing adequate maternal health care to veterans;

- (ii) ensuring that all pregnant veteran patients are appropriately screened for depression, intimate partner/domestic violence, military sexual trauma, post-traumatic stress disorder, anxiety, substance abuse, and postpartum depression;

- (iii) a summary of the current evidence-based and professional guidelines for the screening of conditions listed in subparagraph (ii) of this paragraph;

- (iv) validated, evidence-based tools for screening the conditions listed in subparagraph (ii) of this paragraph; and

- (v) information about follow-up support for patients who may require further evaluation, referral, or treatment including, when available, information about specific community resources and entities licensed by the office of mental health.

(b) The information on veterans reproductive mental health care shall be posted on the department's website. The commissioner shall, in collaboration with the commissioner of mental health and the women veterans coordinator, update and review the information on veterans reproductive mental health, as necessary.

3. The commissioner, in consultation with the commissioner of mental health and the women veterans coordinator, shall: (a) inform providers of the need to raise awareness about veterans reproductive mental health issues; and (b) provide information on the department and the office of mental health's websites regarding how to locate available providers who treat or provide support for veterans reproductive mental health issues including maternal depression including but not limited to, mental health professionals, other licensed professionals, peer support, not-for-profit corporations and other community resources.

4. The commissioner, in consultation with the women veterans coordinator, shall make any regulations necessary to implement this section.

TITLE I-A
CHILD HEALTH INSURANCE PLAN

Section 2510. Definitions.

2511. Child health insurance plan.

§ 2510. Definitions. For the purpose of this title, unless the context clearly requires otherwise:

1. "Applicant" means an eligible organization which submits a proposal under subdivision six of section two thousand five hundred eleven of this title.

1-a. "Applicant for insurance" means the person or persons applying for insurance coverage for a child pursuant to this title.

2. "Approved organization" means an eligible organization approved by the commissioner under subdivision seven of section two thousand five hundred eleven of this title to underwrite a child health insurance plan and an organization approved by the commissioner under subdivision seven-a of section two thousand five hundred eleven of this title.

3. "Eligible organization" means:

(a) a commercial insurer;

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

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

(d) a comprehensive health services plan operating pursuant to regulations of the department of social services or the department of health.

4. "Eligible child" or "eligible children" means a person or persons under the age of thirteen years for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three; born on or after June first, nineteen hundred eighty and

under the age of sixteen for a period commencing on or after January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six; and for a person or persons enrolled in the program on the day before they are sixteen years of age, under the age of seventeen for a period commencing on or after June first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six; and under the age of nineteen for periods commencing on or after January first, nineteen hundred ninety-seven, who meets or meet the criteria in section two thousand five hundred eleven of this title.

5. "Child health insurance plan" means the written undertaking of an approved organization to provide coverage for covered health care services to eligible children under this title.

6. "Period of eligibility" means that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date, provided, however:

(a) the period of eligibility for a child who ceases to be eligible because he or she no longer resides in New York state or has access to or obtained other health insurance coverage, as defined by the commissioner in consultation with the superintendent pursuant to paragraph (c) of subdivision two of section twenty-five hundred eleven of this article, shall end the last day of the month in which the child ceases to be an eligible child; and

(b) the period of eligibility for a child who becomes eligible for medical assistance shall end the last day of the third month after the child becomes eligible for medical assistance; and

(c) the period of eligibility for a child for whom an applicable premium payment has not been paid shall end in accordance with time frames and procedures determined by the commissioner.

(d) effective on or after March first, two thousand twenty-three through March thirty-first, two thousand twenty-seven, subject to extension under Title XXI of the federal social security act, the period of eligibility for pregnant individuals enrolled in the child health insurance plan shall include twelve months postpartum coverage

commencing on the first day of the month following the last day of pregnancy and ending on the last day of the month in which the twelve-month postpartum period ends; provided, however, such postpartum coverage may end prior to the end of the twelve-month period only under the following circumstances: (i) the individual requests voluntary termination; (ii) the individual ceases to be a state resident; (iii) eligibility was determined incorrectly because of error, fraud, abuse, or perjury attributed to the individual; or (iv) the individual dies.

7. "Covered health care services" means: the services of physicians, optometrists, nurses, nurse practitioners, midwives and other related professional personnel which are provided on an outpatient basis, including routine well-child visits; diagnosis and treatment of illness and injury; inpatient health care services; laboratory tests; diagnostic x-rays; prescription and non-prescription drugs, ostomy and other medical supplies and durable medical equipment; radiation therapy; chemotherapy; hemodialysis; outpatient blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies; emergency room services; ambulance services; hospice services; emergency, preventive and routine dental care, including orthodontia but excluding cosmetic surgery; emergency, preventive and routine vision care, including eyeglasses; speech and hearing services; inpatient and outpatient mental health, alcohol and substance abuse services, including children and family treatment and support services, children's home and community based services, assertive community treatment services and residential rehabilitation for youth services which shall be reimbursed in accordance with the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of addiction services and supports, or the office of mental health for rate-setting purposes or any such other fees established pursuant to article forty-three of the mental hygiene law; and health-related services provided by voluntary foster care agency health facilities licensed pursuant to article twenty-nine-I of this chapter; as defined by the commissioner. "Covered health care services" shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is

required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage of such drugs, procedures or supplies shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial.

8. "Subsidy payment" means a payment made to an approved organization for the cost of covered health care services coverage to an eligible child or children.

9. "Premium payment" means: a payment made on behalf of an eligible child for enrollment in the child health insurance plan equal to:

(a) for periods prior to October first, nineteen hundred ninety-seven, twenty-five dollars per year for each child, but no more than one hundred dollars per year per family; and

(b) for periods on or after October first, nineteen hundred ninety-seven, amounts as follows:

(i) no payments are required for eligible children whose family net household income is less than one hundred twenty-six percent of the non-farm federal poverty level or the gross equivalent of such net income;

(ii) nine dollars per month for each eligible child whose family net household income is between one hundred twenty-six percent and one hundred thirty-two percent of the non-farm federal poverty level or the gross equivalent of such net income, but no more than thirty-six dollars per month per family; and

(iii) thirteen dollars per month for each eligible child whose family net household income is between one hundred thirty-three percent and one hundred eighty-five percent of the non-farm federal poverty level or the gross equivalent of such net income, but no more than fifty-two dollars per month per family.

(c) for periods on or after January first, nineteen hundred ninety-nine, amounts as follows:

(i) no payments are required for eligible children whose family net household income is less than one hundred thirty-three percent of the non-farm federal poverty level or the gross equivalent of such net income and, effective August first, two thousand, no payments are

required for eligible children who are American Indians or Alaskan Natives, as defined by the U.S. Department of Health and Human Services; and

(ii) nine dollars per month for each eligible child whose family net household income is between one hundred thirty-three percent and one hundred eighty-five percent of the non-farm federal poverty level or the gross equivalent of such net income, but no more than twenty-seven dollars per month per family; and

(iv) effective September first, two thousand eight, twenty dollars per month for each eligible child whose family gross household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than sixty dollars per month per family;

(v) effective September first, two thousand eight, thirty dollars per month for each eligible child whose family gross household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than ninety dollars per month per family; and

(vi) effective September first, two thousand eight, forty dollars per month for each eligible child whose family gross household income is between three hundred fifty-one percent and four hundred percent of the non-farm federal poverty level, but no more than one hundred twenty dollars per month per family.

(d) for periods on or after July first, two thousand nine, amounts as follows:

(i) no payments are required for eligible children whose family household income is less than one hundred sixty percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the U.S. Department of Health and Human Services, whose family household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) nine dollars per month for each eligible child whose family household income is between one hundred sixty percent and two hundred twenty-two percent of the non-farm federal poverty level, but no more than twenty-seven dollars per month per family; and

(iii) fifteen dollars per month for each eligible child whose family household income is between two hundred twenty-three percent and two

hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iv) thirty dollars per month for each eligible child whose family household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family;

(v) forty-five dollars per month for each eligible child whose family household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(vi) sixty dollars per month for each eligible child whose family household income is between three hundred fifty-one percent and four hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

(e) for periods on or after October first, two thousand twenty-two, amounts as follows:

(i) no payments are required for eligible children whose family household income is less than two hundred twenty-three percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the United States department of health and human services, whose family household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) fifteen dollars per month for each eligible child whose family household income is between two hundred twenty-three percent and two hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iii) thirty dollars per month for each eligible child whose family household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family; and

(iv) forty-five dollars per month for each eligible child whose family household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(v) sixty dollars per month for each eligible child whose family household income is between three hundred fifty-one percent and four

hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

10. "Superintendent" means the superintendent of financial services.

11. "Inpatient health care services" means: inpatient hospital services provided by a general hospital, as defined in article twenty-eight of this chapter, a facility operated by the office of mental health under section 7.17 of the mental hygiene law, a facility issued an operating certificate pursuant to the provisions of article twenty-three or thirty-one of the mental hygiene law and services provided by physicians and other professional personnel on an inpatient basis for covered inpatient services; as defined by the commissioner in consultation with the superintendent.

12. "Group health plan" or "health insurance coverage" shall have the same meanings as set forth in section twenty-one hundred ten of the federal social security act.

13. "Household income" means the sum of the modified adjusted gross income of every individual included in a child's household calculated in accordance with applicable federal law and regulations, as may be amended.

14. "State enrollment center" means the centralized system and operation of eligibility determinations by the state or its contractor for all insurance affordability programs, including the child health insurance program established pursuant to this title.

15. "Insurance affordability programs" means those programs set forth in section 435.4 of title 42 of the code of federal regulations.

§ 2511. Child health insurance plan 1. (a) The commissioner, in consultation with the superintendent, shall establish a program to the extent of funds available therefor through contractual arrangements with approved organizations to provide covered health care services coverage

for eligible children. The availability of coverage for primary and preventive health care services and inpatient health care services coverage shall be continued pending approval of contractual arrangements that include covered health care services coverage and implementation of such coverage to the extent of funds available therefor.

(b) Coverage for covered health care services shall not be effective until such time as contractual arrangements are executed pursuant to this section for such purposes and an eligible child is enrolled in the program.

2. In order to be eligible for a subsidy payment pursuant to subdivision three of this section, a child shall meet the following criteria:

(a) (i) effective January first, nineteen hundred ninety-nine, resides in a household having a net household income at or below one hundred ninety-two percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) or the gross equivalent of such net income; and

(ii) effective July first, two thousand, resides in a household having a gross household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services); and

(iii) effective September first, two thousand eight, resides in a household having a household income at or below four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services);

(b) is not eligible for medical assistance, except that a child who becomes eligible for medical assistance after becoming an eligible child under this title, may be eligible for a subsidy payment pursuant to subdivision three of this section as medical assistance for a period up to three months after becoming eligible for medical assistance; and

(c) does not have health care coverage under insurance, as defined by the commissioner, in consultation with the superintendent. The applicant for insurance shall attest to the source and nature of the child's health care coverage under this paragraph, if any; and

* (e) is a resident of New York state. Such residency shall be demonstrated by adequate proof, as determined by the commissioner, of a

New York state street address. If the child has no street address, such proof may include, but not be limited to, school records or other documentation determined by the commissioner.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (e) is a resident of New York state. Such residency shall be attested to by the applicant for insurance, provided however, the commissioner shall require adequate proof of a New York state street address in circumstances when there is an inconsistency with residency information from other data sources.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

(f) * (i) In order to establish income eligibility under this subdivision at initial application, a household shall provide such documentation specified in subparagraph (iii) of this paragraph, as necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title. The commissioner may verify the accuracy of such income information provided by the household by matching it against income information contained in databases to which the commissioner has access, including the state's wage reporting system pursuant to subdivision five of section one hundred seventy-one-a of the tax law and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (i) In order to establish income eligibility under this subdivision at initial application, a household shall provide the social security numbers for each parent and legally responsible adult who is a member of the household, subject to subparagraph (v) of this paragraph. The commissioner shall determine eligibility based on income information contained in databases to which the commissioner has access, including the state's wage reporting system pursuant to subdivision five of section one hundred seventy-one-a of the tax law and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of

section one hundred seventy-one-b of the tax law. The commissioner shall require an attestation by the household that the income information obtained from electronic data sources is accurate. Such attestation shall include any other household income information not obtained from an electronic data source that is necessary to determine a child's financial eligibility for a subsidy payment under this title. If the attestation is reasonably compatible with information obtained from available data sources, no further information or documentation is required. If the attestation is not reasonably compatible with information obtained from available data sources, documentation shall be required as specified in subparagraph (iii) of this paragraph.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

(ii) In order to establish income eligibility under this subdivision at recertification, the commissioner may make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's enrollment file or other more current information contained in databases to which the commissioner has access, including the state's wage reporting system and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law. The commissioner shall require an attestation by the household that the income information contained in the enrollment file or obtained from electronic data sources is accurate. Such attestation shall include any other household income information not obtained from an electronic data source that is necessary to redetermine a child's financial eligibility for a subsidy payment under this title. In the event that there is an inconsistency between the income information attested to by the household and any information obtained by the commissioner from other sources pursuant to this subparagraph, and such inconsistency is material to the household's eligibility for a subsidy payment under this title, the commissioner shall require the household to provide income documentation as specified in subparagraph (iii) of this paragraph.

* (iii) Income documentation shall include, but not be limited to, one or more of the following for each parent and legally responsible adult

who is a member of the household and whose income is available to the child;

(A) current annual income tax returns;

(B) paycheck stubs;

(C) written documentation of income from all employers; or

(D) written documentation of income eligibility of a child for free or reduced breakfast or lunch through the school meal program certified by the child's school, provided that:

(I) the commissioner may verify the accuracy of the information provided in the same manner and way as provided for in subparagraph (ii) of this paragraph; and

(II) such documentation may not be suitable proof of income in the event of a material inconsistency in income after the commissioner has performed verification pursuant to subparagraph (ii) of this paragraph; or

(E) other documentation of income (earned or unearned) as determined by the commissioner, provided, however, such documentation shall set forth the source of such income.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (iii) If the attestation of household income required by subparagraphs (i) and (ii) of this paragraph is not reasonably compatible with information obtained from data sources, further information, including documentation, shall be required. Income documentation shall include, but not be limited to, one or more of the following for each parent and legally responsible adult who is a member of the household and whose income is available to the child;

(A) current annual income tax returns;

(B) paycheck stubs;

(C) written documentation of income from all employers; or

(D) written documentation of income eligibility of a child for free or reduced breakfast or lunch through the school meal program certified by the child's school, provided that:

(I) the commissioner may verify the accuracy of the information provided in the same manner and way as provided for in subparagraph (ii) of this paragraph; and

(II) such documentation may not be suitable proof of income in the

event of a material inconsistency in income after the commissioner has performed verification pursuant to subparagraph (ii) of this paragraph; or

(E) other documentation of income (earned or unearned) as determined by the commissioner, provided, however, such documentation shall set forth the source of such income.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

* (iv) In the event a household does not provide income documentation required by subparagraph (iii) of this paragraph within two months of the approved organization's request, the approved organization shall disenroll the child at the end of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments made by the state on behalf of children enrolled during this two month period.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (iv) In the event a household does not provide income documentation required by subparagraph (iii) of this paragraph within two months of the approved organization's or state enrollment center's request, whichever is applicable, the approved organization or state enrollment center shall disenroll the child at the end of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments made by the state on behalf of children enrolled during this two month period.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

* (v) In the event a household chooses not to provide the social security numbers required by subparagraph (ii) of this paragraph, such household shall provide income documentation specified in subparagraph (iii) of this paragraph as a condition of the child's enrollment. Nothing in this paragraph shall be construed as obligating a household to provide social security numbers of parents or legally responsible adults as a condition of a child's enrollment or eligibility for a subsidy payment under this title.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (v) In the event a household chooses not to provide the social security numbers required by subparagraphs (i) and (ii) of this paragraph, such household shall provide income documentation specified in subparagraph (iii) of this paragraph as a condition of the child's enrollment. Nothing in this paragraph shall be construed as obligating a household to provide social security numbers of parents or legally responsible adults as a condition of a child's enrollment or eligibility for a subsidy payment under this title.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

* (vi) Any income verification response by the department of taxation and finance pursuant to subparagraphs (i) and (ii) of this paragraph shall not be a public record and shall not be released by the commissioner, the department of taxation and finance or an approved organization except pursuant to this paragraph. Information disclosed pursuant to this paragraph shall be limited to information necessary for verification. Information so disclosed shall be kept confidential by the party receiving such information. Such information shall be expunged within a reasonable time to be determined by the commissioner and the department of taxation and finance.

* NB Effective until January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Part D § 76 sb h)

* (vi) Any income verification response by the department of taxation and finance pursuant to subparagraphs (i) and (ii) of this paragraph shall not be a public record and shall not be released by the commissioner, the department of taxation and finance, an approved organization, or the state enrollment center, except pursuant to this paragraph. Information disclosed pursuant to this paragraph shall be limited to information necessary for verification. Information so disclosed shall be kept confidential by the party receiving such information. Such information shall be expunged within a reasonable time to be determined by the commissioner and the department of taxation and finance.

* NB Effective January 1, 2014 or a later date to be determined by the commissioner of health (see chapter 56 of 2013 Pt. D § 76 sub h)

* (g) (i) Notwithstanding any inconsistent provision of law to the contrary and subject to the availability of federal financial participation under title XIX of the federal social security act, a child under the age of nineteen shall be presumed to be eligible for subsidy payments and temporarily enrolled for coverage under this title, once during a twelve month period, beginning on the first day of the enrollment period following the date that an approved organization determines, on the basis of preliminary information, that a child's net household income does not exceed the income level specified in title eleven of article five of the social services law for children eligible for medical assistance based on such child's age. The temporary enrollment period shall continue until the earlier of the date an eligibility determination is made pursuant to this title or title eleven of article five of the social services law, or two months after the date temporary enrollment begins; provided however, a temporary enrollment period may be extended in the event an eligibility determination under this title or title eleven of article five of the social services law is not made within such two month period through no fault of the applicant for insurance for medical assistance. The commissioner shall assure that children who are enrolled pursuant to this paragraph receive the appropriate follow-up for a determination of eligibility for benefits under this title or title eleven of article five of the social services law prior to the termination of the temporary enrollment period. The commissioner shall assure that children and their families are informed of all available enrollment sites in accordance with subdivision nine of this section.

(ii) Effective September first two thousand seven, through March thirty-first, two thousand fourteen temporary enrollment pursuant to subparagraph (i) of this paragraph shall be provided only to children who apply for recertification of coverage under this title who appear to be eligible for medical assistance under title eleven of article five of the social services law.

* NB Expires July 1, 2025

* (h) The commissioner may, in consultation with the superintendent, promulgate rules and regulations necessary to prevent fraud and abuse in eligibility determinations made by approved organizations pursuant to this subdivision.

* NB Expires July 1, 2025

(i) Notwithstanding any inconsistent provision of law, rule or regulation:

(i) A newborn child who meets the eligibility criteria set forth in this subdivision or subdivision five of this section, as determined by an approved organization or the health insurance exchange marketplace, whichever is applicable, shall be enrolled retroactively to the first day of the month in which the child is born, provided that the applicant for insurance submits a completed and signed application and required information and documentation within sixty days of the child's birth.

(ii) A newborn child shall be presumed eligible for subsidy payments under this subdivision or eligible for coverage under subdivision five of this section, provided that the applicant for insurance submits a completed and signed application within sixty days of the child's birth. Once eligibility is determined by the approved organization or the health insurance exchange marketplace, whichever is applicable, on the basis of preliminary information, the child shall be enrolled retroactively to the first day of the month in which the child is born. All other procedures and standards regarding presumptive enrollment applicable to eligible children enrolled under this title and specified in state contracts with approved organizations or implemented by the health insurance exchange marketplace, whichever is applicable, shall apply to presumptive enrollment of newborn children.

(j) Where an application for recertification of coverage under this title contains insufficient information for a final determination of eligibility for continued coverage, a child shall be presumed eligible for a period not to exceed the earlier of two months beyond the preceding period of eligibility or the date upon which a final determination of eligibility is made based on the submission of additional data. In the event such additional information is not submitted within two months of the approved organization's or state enrollment center's request, whichever is applicable, the approved organization or state enrollment center shall disenroll the child following the expiration of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments received on behalf of children enrolled during this two month period.

2-a. (a) An approved organization that has reasonable cause to believe that an applicant for insurance, parent or legally responsible adult has provided false income information may submit tax returns and any other available income information, including, if not prohibited by federal law for purposes of income verification, social security account numbers, to the department as may be necessary to determine income eligibility. The department shall promptly furnish to the department of taxation and finance, pursuant to the agreements authorized by subdivision five of section one hundred seventy-one-a and subdivision four of section one hundred seventy-one-b of the tax law, the names, address and social security account numbers, if available, of the parents and legally responsible adults who are members of the household, together with a request that the department of taxation and finance, pursuant to those agreements, promptly ascertain insofar as is possible, and from the most recent available data, whether the collective income reported by those individuals exceeds the income eligibility level for that household, as determined by the department in compliance with paragraph (a) of subdivision two of this section. The department, in consultation with the department of taxation and finance, shall establish a methodology for comparing numerical equivalents. In ascertaining whether a household's income exceeds the income eligibility threshold transmitted by the department, the department of taxation and finance shall also examine information available pursuant to section one hundred seventy-one-a of the tax law where any of the named individuals have failed to file a New York state income tax return for the most recent filing year or where there is an indication, from the department or otherwise, that the individual's income may have changed. Reliance on such section one hundred seventy-one-a information shall be specially indicated in the department of taxation and finance's response. This provision shall not be construed to authorize the department of taxation and finance to disclose any figure on any personal income tax return. The department shall promptly inform the approved organization of the response from the department of taxation and finance. Submission of income information for verification shall not delay the application of any other provision of this section to an applicant for insurance or an enrolled child.

(b) Before an approved organization submits income information to the department for verification with the department of taxation and finance, it shall:

(i) provide the applicant for insurance with notification of its intent to seek such verification;

(ii) notify the applicant for insurance of the confidentiality and expungement provisions contained in paragraph (c) of this subdivision; and

(iii) provide the applicant for insurance with the opportunity to review and modify the income information.

(c) Such income information and verification response by the department of taxation and finance shall not be a public record and shall not be released by the department, the department of taxation and finance or the approved organization except pursuant to this subdivision. Information disclosed pursuant to this section shall be limited to information necessary for verification. Information so disclosed shall be kept confidential by the party receiving such information. Such income information shall be expunged within a reasonable time to be determined by the department and the department of taxation and finance.

2-b. (a) For purposes of claiming federal financial participation under paragraph nine of subsection (c) of section twenty-one hundred five of the federal social security act, a household shall provide:

(i) the social security number for the applicant to be verified by the commissioner in accordance with a process established by the social security administration pursuant to federal law, or

(ii) documentation of citizenship and identity of the applicant consistent with requirements under the medical assistance program, as specified by the commissioner on the initial application.

(b) Pending receipt of the information required by subparagraph (i) of paragraph (a) of this subdivision, an initial application shall continue to be processed by an approved organization or enrollment facilitator and a child shall be presumptively enrolled in the program in accordance with procedures and timeframes currently specified in contracts.

2-c. Express lane eligibility. (a) Notwithstanding any inconsistent

provision of law, rule or regulation, the commissioner is authorized to (i) establish standards and procedures for express lane enrollment and renewal implemented in accordance with section 2107(e)(1)(B) of the federal social security act, including but not limited to reliance on a finding made by an express lane agency, as defined in section 1902(e)(13)(F) of the federal social security act, to determine whether a child meets one or more of the eligibility criteria set forth in subdivision two of this section; (ii) specify such standards and procedures in the state child health plan established under title XXI of the federal social security act and applicable contracts with approved organizations and enrollment facilitators; and (iii) waive any information and documentation requirements set forth in this section necessary to implement express lane eligibility pursuant to standards and procedures established under subparagraphs (i) and (ii) of this paragraph; provided, however, that information and documentation required pursuant to subdivision two-b of this section may not be waived.

(b) Subject to federal approval, such standards and procedures shall specify that information and documentation regarding citizenship and immigration status collected by an express lane agency and provided to the commissioner for the purpose of express lane eligibility may be used to satisfy the requirements of subdivision two-b of this section.

(c) Such standards and procedures shall also include a process for determining enrollment error rates and implementing corrective actions as required by section 1902(e)(13)(E) of the federal social security act.

3. Subsidy payments shall be made, pursuant to subdivision eight of this section, to approved organizations for the purposes of subsidizing the entire cost of coverage for eligible children meeting the criteria of subdivision two of this section. Notwithstanding any inconsistent provision of this subdivision, the total annual aggregate cost-sharing with respect to all eligible children in a family under this section shall not exceed amounts provided pursuant to applicable federal law. In order to be eligible for a subsidy payment pursuant to this subdivision a premium payment shall be paid for an eligible child in accordance with the provisions of subdivision nine of section twenty-five hundred ten of

this title. Nothing herein shall preclude payment of the premium on behalf of an eligible child on a monthly, quarterly, semi-annual or annual basis.

4. Households shall report to the approved organization or state enrollment center, whichever is applicable, within thirty days, any changes in New York state residency or health care coverage under insurance that may make a child ineligible for subsidy payments pursuant to this section. Any individual who, with the intent to obtain benefits, willfully misstates income or residence to establish eligibility pursuant to subdivision two of this section or willfully fails to notify an approved organization or state enrollment center of a change in residence or health care coverage pursuant to this subdivision shall repay such subsidy to the commissioner. Individuals seeking to enroll children for coverage shall be informed that such willful misstatement or failure to notify shall result in such liability.

4-a. Any individual who, with the intent to obtain benefits, willfully misstates income or residence to establish eligibility pursuant to subdivision two of this section or willfully fails to notify an approved organization of an increase in income or change in residence pursuant to subdivision two of this section shall repay such subsidy to the commissioner. Individuals seeking to enroll children for coverage shall be informed that such willful misstatement or failure to notify shall result in such liability.

5. Notwithstanding any inconsistent provisions of subdivision two of this section, an individual who meets the criteria of paragraphs (b) and (c) of subdivision two of this section but not the criteria of paragraph (a) of such subdivision may be enrolled for covered health care services, provided however, that an approved organization shall not be eligible to receive a subsidy payment for providing coverage to such individuals. The cost of coverage shall be determined by the commissioner, in consultation with the superintendent and shall be no more than the cost of providing such coverage.

5-a. Obligations of approved organizations or the state enrollment

center. (a) An approved organization or state enrollment center, whichever is applicable, shall have the obligation to review all information provided pursuant to subdivision two of this section and shall not certify or recertify a child as eligible for a subsidy payment unless the child meets the eligibility criteria.

(b) An approved organization or state enrollment center, whichever is applicable, shall promptly review all information relating to a potential change in eligibility based on information provided pursuant to subdivision four of this section. Within at least thirty days after receipt of such information, the approved organization or state enrollment center shall make a determination whether the child is still eligible for a subsidy payment and shall notify the household and the commissioner if it determines the child is not eligible for a subsidy payment.

(c) Any approved organization which engages in a pattern and practice of enrolling or recertifying children who are ineligible pursuant to subdivision two of this section, as determined by the commissioner, in consultation with the superintendent, shall be required to repay all subsidy payments received on account of ineligible children. Improper enrollment based upon a good faith reliance on documentation which appears accurate on its face shall not constitute a pattern or practice. Any such approved organization may also be removed as an approved organization, provided however, that eligible children shall continue to receive services until such time as the orderly transition to other approved organizations can be effected.

6. The commissioner shall, in consultation with the superintendent, establish guidelines for the submission of proposals by eligible organizations for the purposes of providing covered health care services coverage to eligible children including, but not limited to, the following components:

(a) standards for individual enrollment including mechanisms for presumptive eligibility and annual recertification;

(b) standards for provider enrollment;

(c) standards for scope of covered health care service benefits;

(d) standards for health care provider payment methodologies, provided however, that levels and methods of payment shall be consistent with

those provided under similar insurance plans;

(e) standards for appropriate utilization review, quality assurance and case management mechanisms; and

(f) such other criteria which may be deemed necessary.

6-a. The commissioner, in consultation with the superintendent, may establish a program for cards issued to eligible children which can store or access information electronically, including the identity of the child and such other medical data and information as the commissioner, in consultation with the superintendent, may prescribe.

7. (a) A proposal submitted by an eligible organization shall meet the following criteria:

(i) designate the geographic area to be served by the program, and estimate the number of eligible participants and actual participants in such designated area;

(ii) assure access to and delivery of high quality, appropriate covered health care services and, when applicable, include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

(iii) describe the procedures for marketing and determining eligibility for the health care coverage plan in the program location, including the designation of other entities which may perform such functions under contract with the organization;

(iv) describe proposed health care provider payment methodologies;

(v) describe in detail the estimated expenses, including personnel costs and other types of administrative expenses which will be incurred in the development and implementation of the program;

(vi) describe the quality assurance, utilization review and case management mechanisms to be implemented;

(vii) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

(viii) describe the benefit package to be offered by the program and the cost of such benefit package;

(ix) describe the provisions for arranging for or offering conversion coverage in the event of termination of coverage under this title;

(x) demonstrate financial feasibility of the program;

(xi) describe the premium, copayments and deductibles to be paid by program participants who are ineligible for subsidy payments; and

(xii) include such other information as the commissioner and the superintendent may deem appropriate.

(b) The commissioner, in consultation with the superintendent, shall make a determination whether to approve, disapprove or recommend modification of the proposal. In order for a proposal to be approved by the commissioner, the proposal must also be approved by the superintendent with respect to the provisions of subparagraphs (ix) and (xii) of paragraph (a) of this subdivision.

(c) The commissioner, in consultation with the superintendent, shall ensure, to the extent possible, that child health insurance plan coverage is available in all geographic areas. The commissioner may approve more than one approved organization to serve all or part of a geographic area.

7-a. (a) Notwithstanding any inconsistent provisions of subdivisions one and three of section two thousand five hundred ten of this title, subdivisions six and seven of this section, subject to paragraph (b) of this subdivision, and section one hundred sixty-three of the state finance law, the commissioner may contract with organizations approved under section three hundred sixty-four-j of the social services law, without a competitive bid or request for proposal process, to provide covered health care services coverage for eligible children pursuant to this title.

(b) In order to be approved pursuant to this subdivision, an organization shall meet the criteria set forth in subdivision seven of this section and shall comply with standards established by the commissioner, in consultation with the superintendent, pursuant to subdivision six of this section.

(c) Organizations approved pursuant to this subdivision shall comply with the requirements of this title and contractual provisions established thereunder, title XXI of the federal social security act and any implementing federal regulations, and requirements set forth in the state child health plan established pursuant to title XXI of the federal social security act.

(d) Notwithstanding any inconsistent provision of section one hundred

twelve or one hundred sixty-three of the state finance law, at the discretion of the commissioner, without a competitive bid or request for proposal process, contractual arrangements with approved organizations, as defined in subdivision two of section twenty-five hundred ten of this article, in effect in two thousand seven may be extended to any period on and after July first, two thousand seven to provide an uninterrupted continuation of services and may be amended as deemed necessary.

8. The commissioner shall determine the amount of funds to be allocated to an approved organization for the purposes described in subdivision one of this section within such funds which may be available for the purposes of this article. (a) Subsidy payments made to approved organizations on and after April first, two thousand five through March thirty-first, two thousand six, shall be at amounts approved prior to April first, two thousand five. Applications for increases to subsidy payments submitted by approved organizations to the superintendent on or after January first, two thousand five, shall not be considered for approval until after March thirty-first, two thousand six. (b) Further, subsidy payments made to approved organizations on and after April first, two thousand seven through March thirty-first, two thousand eight, shall be at amounts approved prior to April first, two thousand seven. Applications for increases to subsidy payments submitted by approved organizations to the superintendent on or after January first, two thousand seven, shall not be considered for approval until after March thirty-first, two thousand eight. (c) Nothing in this subdivision shall prohibit decreases in subsidy payments in accordance with relevant contract provisions.

(d)(i) Effective April first, two thousand nine, payment for marketing and facilitated enrollment activities set forth in subdivision nine of this section and included in subsidy payments made to approved organizations providing such services pursuant to a contract with the state shall be limited to an amount determined annually by the commissioner.

(ii) Such subsidy payments shall be adjusted by the commissioner to remove any costs of approved organizations in excess of the amount determined in accordance with subparagraph (i) of this paragraph based on cost reports submitted to the department by approved organizations.

(f) The commissioner shall adjust subsidy payments made to approved organizations on and after April first, two thousand eleven through March thirty-first, two thousand twelve, so that the amount of each such payment is reduced by one and seven-tenths percent.

(g) The commissioner may increase subsidy payments made to approved organizations that voluntarily participate in the multi-payor patient centered medical home program to reflect additional costs associated with enhanced payments made to certified medical homes by approved organizations as required by article twenty-nine-AA of this chapter.

(h) Notwithstanding any inconsistent provision of this title, articles thirty-two and forty-three of the insurance law and subsection (e) of section eleven hundred twenty of the insurance law, for the period April first, two thousand fourteen through March thirty-first, two thousand fifteen, subsidy payments made to approved organizations shall be at amounts approved prior to April first, two thousand fourteen.

(i) Notwithstanding any inconsistent provision of this title, articles thirty-two and forty-three of the insurance law and subsection (e) of section eleven hundred twenty of the insurance law:

(i) The commissioner shall, subject to approval of the director of the division of the budget, develop reimbursement methodologies for determining the amount of subsidy payments made to approved organizations for the cost of covered health care services coverage provided pursuant to this title for payments made on and after January first, two thousand twenty-four.

(ii) Effective January first, two thousand twenty-three, the commissioner shall coordinate with the superintendent of financial services for the transition of the subsidy payment rate setting function to the department and, in conjunction with its independent actuary, review reimbursement methodologies developed in accordance with subparagraph (i) of this paragraph. Notwithstanding section one hundred sixty-three of the state finance law, the commissioner may select and contract with the independent actuary selected pursuant to subdivision eighteen of section three hundred sixty-four-j of the social services law, without a competitive bid or request for proposal process. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to the adequacy

of subsidy payment amounts in relation to the population to be served adjusted for case mix, the scope of services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

9. The commissioner shall, within amounts available therefor, contract with community-based and other marketing organizations for purposes of public education, outreach, and recruitment of eligible children, including the distribution of applications and information regarding enrollment. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of approved organizations, and the extent to which such organizations are able to effectively target efforts in geographic regions where the proportion of eligible children enrolled under this title are lower than in other geographic regions of the state. Community-based organizations shall include, but not be limited to: day care centers, schools, community-based diagnostic and treatment centers, and hospitals.

10. Notwithstanding any other law or agreement to the contrary, and except in the case of a child or children who also becomes eligible for medical assistance, benefits under this title shall be considered secondary to any other plan of insurance or benefit program, except the children and youth with special health care needs support services program and the early intervention program, under which an eligible child may have coverage.

11. (a) An approved organization shall submit required reports and information to the commissioner in such form and at times, at least annually, as may be required by the commissioner and specified in contracts and official department of health administrative guidance, in order to evaluate the operations and results of the program and quality of care being provided by such organizations. Such reports and information shall include, but not be limited to, enrollee demographics (applicable only until the state enrollment center is implemented), program utilization and expense, patient care outcomes and patient specific medical information, including encounter data maintained by an approved organization for purposes of quality assurance and oversight.

Any information or data collected pursuant to this paragraph shall be kept confidential in accordance with Title XXI of the federal social security act or any other applicable state or federal law.

(b) In the event an approved organization fails to submit any required report and information, as specified in contracts and official department of health administrative guidance, on or before the due date specified by the commissioner, the commissioner may reduce the approved organization's subsidy payments by up to a total of two percent each month for a period beginning on the first day of the calendar month following the original due date of the required report and information and continuing until the last day of the calendar month in which the required report and information are submitted; provided however, an approved organization shall not be subject to the percentage reduction under the following conditions: (i) for any new report for which such organization did not have reasonable notice which shall be at least sixty days notice of its requirement, data and submission specifications, and due date by certified mail to the approved organization's chief financial officer; or (ii) for any report, upon a finding by the commissioner that such report was not submitted on a timely basis for good cause, which may include, but not be limited to, additional time required to modify or add to computer data systems.

12. The commissioner shall, in consultation with the superintendent, establish procedures to coordinate the child health insurance plan with the medical assistance program, including but not limited to, procedures to maximize enrollment of eligible children under those programs by identification and transfer of children who are eligible or who become eligible to receive medical assistance and procedures to facilitate changes in enrollment status for children who are ineligible for subsidies under this section and for children who are no longer eligible for medical assistance in order to facilitate and ensure continuity of coverage. The commissioner shall review, on an annual basis, the eligibility verification and recertification procedures of approved organizations under this title to insure the appropriate enrollment of children. Such review shall include, but not be limited to, an audit of a statistically representative sample of cases from among all approved organizations and shall be applicable to any period during which an

approved organization's responsibilities include determining eligibility. In the event such review and audit reveals cases which do not meet the eligibility criteria for coverage set forth in this section, that information shall be forwarded to the approved organization and the commissioner for appropriate action.

12-a. The commissioner shall establish procedures to audit approved organizations for compliance with the requirements of this title, including the requirements of subdivision twelve of this section, contractual provisions established thereunder and advisory memoranda issued by the commissioner, title XXI of the federal social security act and any implementing federal regulations, and requirements set forth in the state child health plan established pursuant to title XXI of the federal social security act. Approved organizations shall comply with such procedures and make available any data necessary to perform such audits. Audit procedures shall include, but not be limited to, the following:

- (a) standards and procedures for a preliminary audit to be conducted on no more than an annual basis;

- (b) standards and procedures for the submission of a plan of correction by an approved organization, including time periods allowed to implement such plan of correction;

- (c) standards and procedures for a second audit, including an exit conference which provides an approved organization the opportunity to rebut the composition of the audit sample as representative prior to recovery of subsidy payments and the imposition of penalties;

- (d) standards and procedures for recovery of subsidy payments made for ineligible children, which, notwithstanding any inconsistent provisions of this title, may include recoveries based on extrapolated findings from a statistically representative sample of cases which shall be actuarially based and consistent with accepted auditing standards; and

- (e) standards and procedures for the imposition of penalties for substantial noncompliance, which may include, but not be limited to, financial penalties in addition to penalties set forth in section twelve of this chapter and consistent with applicable federal standards, as specified in contracts, and contract termination; provided however

- (f) audit standards and procedures established pursuant to this

section, including penalties, shall be applicable to eligibility determinations made by approved organizations only for periods during which an approved organization's responsibilities include making such eligibility determinations.

14. The commissioner, in consultation with the superintendent, shall enter into agreements with one or more persons, not-for-profit corporations, or other organizations, other than a state employee, official or agency, for the performance of a comprehensive evaluation of the implementation and effectiveness of the child health insurance program. Notwithstanding any inconsistent provision of law, the commissioner may allocate and distribute from funds otherwise available for distribution for purposes of this title an amount not to exceed five hundred thousand dollars for the costs of such evaluation. The evaluation shall include, but not be limited to:

(a) the overall effect of the child health insurance program on access to, utilization and quality of primary and preventive health care services, including, but not limited to, patterns of service utilization, geographic availability of service providers, possible reductions in uncompensated care as a result of the program, and enrollee satisfaction with program administration, services and quality;

(b) the impact of the child health insurance program on the health status of program participants, including the comparative impact on families that have a child enrolled in the program and other children that are not eligible and do not have coverage;

(c) the effect of the child health insurance program on emergency room utilization, including the effectiveness of preventing inappropriate utilization;

(d) the geographic accessibility of the child health insurance program, including the availability and accessibility of service providers, premium levels and premium increases;

(e) the effect of community-based and statewide outreach education efforts;

(f) the results of a statistically valid sampling of cases verifying certification and recertification of eligibility for subsidy payments under this title including but not limited to data on failure by approved organizations to adequately verify enrollee eligibility;

(g) any recommendations for programmatic changes to improve the child health insurance program based on program evaluation and enrollee satisfaction data; and

(h) a cost and patient outcome comparison of indemnity plans and managed care plans offered under this program.

A preliminary evaluation shall be submitted to the governor and the legislature by April first, nineteen hundred ninety-five and a further evaluation shall be submitted by January first, nineteen hundred ninety-six.

14-a. The commissioner shall enter into an agreement with one or more persons, not-for-profit corporations, or other organizations, other than a state employee, official or agency, for comprehensive research concerning the health care coverage of children in New York state. The organization conducting the research shall, at least annually, issue a report of its findings to the governor and the legislature. The research shall include, but not be limited to:

(a) a survey of the uninsured in the state;

(b) on-going comprehensive studies of the characteristics of uninsured children and their families, including demographic characteristics, and reasons such children and families are uninsured;

(c) the collection and dissemination of data and other relevant information relating to the health care coverage of children and their families; and

(d) a review of such factors relating to the uninsured in New York state as the commissioner, in consultation with the superintendent, shall require.

15. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process:

(a) contractual arrangements with approved organizations to provide primary and preventive health care services coverage for eligible children, or with organizations for purposes of public education, outreach and recruitment of eligible children, in effect in nineteen

hundred ninety-three may be extended to provide for primary and preventive health care services coverage for eligible children or public education, outreach and recruitment of eligible children in nineteen hundred ninety-four and nineteen hundred ninety-five and those contractual arrangements with approved organizations to provide primary and preventive health care services coverage for eligible children in effect for nineteen hundred ninety-five may be extended through June thirtieth, nineteen hundred ninety-six to provide an uninterrupted continuation of services and additional time for program evaluation and may be amended as may be necessary, provided, however, that the commissioner shall periodically review the process of ensuring adequate participation of approved organizations under this section; and

(b) contractual arrangements with approved organizations to provide primary and preventive health care services coverage for eligible children, or with organizations for purposes of public education, outreach and recruitment of eligible children in effect in the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six may be extended for public education, outreach and recruitment of eligible children through December thirty-first, nineteen hundred ninety-six and to provide for primary and preventive health care services coverage for eligible children through such periods for which such coverage continues to apply prior to the addition of coverage for inpatient health care services to provide an uninterrupted continuation of services and may be amended as may be necessary.

* 16. The commissioner and the commissioner of social services shall jointly develop a simplified application form for coverage under this title, the medical assistance program and the federal women, infants and children program, and shall also develop appropriate verification and sampling procedures for the child health insurance plan in order to facilitate the appropriate enrollment of eligible children into the child health insurance plan, the medical assistance program, and the women, infants and children program. Nothing in this subdivision shall be construed to require that eligibility documentation requirements for the services under this title shall apply to the medical assistance program, nor shall this subdivision be construed to preclude eligibility for any person pending the development of that application. Such

application shall be available for use by local social services districts and approved organizations under this title by June thirtieth, nineteen hundred ninety-four.

* NB Expired July 1, 2007

16-a. The commissioner shall develop a simplified recertification form for use by approved organizations in renewing coverage for eligible children under this title. The form shall include requests only for such information that is: (i) reasonably necessary to determine continued eligibility for coverage under this title; and (ii) subject to change since the date of the household's initial application.

17. The commissioner, in consultation with the superintendent, is authorized to establish and operate a child health information service which shall utilize advanced telecommunications technologies to meet the health information and support needs of children, parents and medical professionals, which shall include, but not be limited to, treatment guidelines for children, treatment protocols, research articles and standards for the care of children from birth through eighteen years of age. Such information shall not constitute the practice of medicine, as defined in article one hundred thirty-one of the education law.

18. Premium Assistance Program. (a) The commissioner shall establish a premium assistance program for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of an eligible child, as defined in subdivision four of section twenty-five hundred ten of this article, contingent upon:

(i) a determination by the commissioner that the purchase of family coverage under this subdivision is cost effective relative to the amount the state would pay to obtain coverage under this title solely for the eligible child or children; and

(ii) the availability of federal financial participation in accordance with a waiver application submitted by the commissioner and approved by the secretary of the department of health and human services.

(b) The commissioner shall establish and specify standards for the implementation of the premium assistance program in the federal waiver application, including, but not limited to, the following:

(i) standards for eligibility of children and families for and enrollment in the premium assistance program which shall include, at a minimum, the eligibility criteria set forth in subdivision two of this section; provided that:

(A) participation in the program for a child who resides in a household having a household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall be voluntary and an eligible child may disenroll from the premium assistance program at any time and enroll in individual coverage under this title; and

(B) participation in the program for a child who resides in a household having a household income between two hundred fifty-one and four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) and meets certain eligibility criteria shall be mandatory. A child in this income group who meets the criteria for enrollment in the premium assistance program shall not be eligible for individual coverage under this title;

(ii) standards for required levels of employer contributions toward the cost of premiums for family coverage;

(iii) standards for the level of state payment toward the cost of premiums for family coverage;

(iv) standards for the scope and level of benefits to be provided in the premium assistance program;

(v) standards for data collection including, but not limited to, data regarding the substitution of health insurance coverage that would be provided to eligible children in the absence of family coverage purchased pursuant to this subdivision; and

(vi) any other standards deemed necessary by the commissioner to implement the premium assistance program.

(c) The state share of the cost of the premium assistance program, if implemented, shall be funded within amounts appropriated for the purpose of providing healthcare coverage for uninsured and underinsured children pursuant to this title.

19. Claims submitted to an approved organization for payment for

medical care, services, or supplies furnished by an out-of-network health care provider must be submitted within fifteen months of the date the medical care, services, or supplies were furnished to an eligible person to be valid and enforceable against the approved organization. If a claim by an out-of-network health care provider is not submitted within fifteen months of the date that the medical care, services or supplies were furnished and the claim is subsequently denied by the approved organization for that reason, such out-of-network health care provider shall not seek payment for such medical care, services or supplies from the enrollee. This deadline for claims submission shall not apply where the claims submission is warranted to address findings or recommendations identified in a state or federal audit except where such audit also indicates that an inappropriate provider payment was solely the fault of the out-of-network health care provider.

20. For approved organizations with negotiated rates of payment for inpatient hospital services under contracts in effect on April first, two thousand eight, that have a payment rate methodology for such inpatient hospital services that utilizes rates calculated by the department of health pursuant to paragraph (a) or (a-2) of subdivision one of section twenty-eight hundred seven-c of the public health law for patients under the medical assistance program, such rate shall not include adjustments pursuant to subdivision thirty-three of section twenty-eight hundred seven-c of this chapter for contract periods prior to January first, two thousand ten.

21. The commissioner may make any necessary amendments to a contract pursuant to this section with an approved organization, as defined in subdivision two of section twenty-five hundred ten of this title, to allow such approved organization to participate as a qualified health plan in a state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

22. Notwithstanding the provisions of this title and effective on and after January first, two thousand twenty-three, the consultative,

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

TITLE 1-B

ADOLESCENT PREGNANCY PREVENTION AND SERVICES PROGRAM

Section 2515. Definitions.

2515-a. Administration.

2515-b. Community service project plans.

2515-c. Use of funds.

§ 2515. Definitions. For the purposes of this title the following definitions shall apply:

1. "Eligible adolescent" means a person aged twenty-one or under who is at risk of becoming a parent, is pregnant, or is a parent.

2. "Services for eligible adolescents" means those services, including but not limited to: vocational and educational counseling, job skills training, family life and parenting education, life skills development, coordination, case management, primary preventive health care, pregnancy and child nutrition counseling for expectant mothers to curb the incidence of childhood obesity, family planning, social and recreational programs, child care, outreach and advocacy, follow-up on service

utilization, crisis intervention, and efforts to stimulate community interest and involvement.

3. "Community council" means a group of volunteers responsible for the development of the community service project plan which, to the extent possible, represents the needs and values of the community and which includes representatives of the following community groups or organizations: community residents, including youths; local government; the business community; service providers, including agencies providing vocational, housing services, child care agencies serving youth and youth services agencies; charitable organizations; health providers; educational institutions; family planning agencies; and community networks and coalitions.

§ 2515-a. Administration. 1. The department is authorized to request and receive community service project plans, as defined in section twenty-five hundred fifteen-b of this title. Such projects shall be limited to a twelve month duration but may, with the approval of such department, be renewed for additional periods based on demonstrated effectiveness, need, and availability of funds. The department shall offer technical assistance to applicants for and operators of community service projects. Technical assistance shall be provided for, but shall not be limited to, the following activities: development of community service plans, overall program planning, contract development, budgeting, and designing local client-specific data collection systems.

2. The department shall review such community service project plans. The commissioner, within appropriations made therefor, may approve such plans for funding in accordance with the provisions of this title. In approving or disapproving the funding of such plans, the commissioner shall only approve projects which meet the requirements set forth in section twenty-five hundred fifteen-b of this title which demonstrate clear coordinating activities with local social services districts and other available city, school, county, state or federally funded programs and shall give priority to projects which:

(a) stress the development and expansion of primary prevention

programs aimed at decreasing the incidence of adolescent pregnancy, and the establishment of a comprehensive and coordinated approach to prevent initial and repeated pregnancy and to deal more effectively with the consequences associated with adolescent parenting;

(b) serve a geographic area where there is a large number of eligible adolescents, or a high rate of adolescent pregnancy;

(c) serve a geographic area where the incidence of infant mortality, low birth weight infants, childhood obesity and the prevalence of low-income families are high and where the availability or accessibility of services for eligible adolescents is low;

(d) utilize existing community resources; and

(e) maximize the use of federal, or other state, private and local resources.

§ 2515-b. Community service project plans. 1. Plans for community service projects may be submitted to the department by not-for-profit agencies or by county or municipal governments, or any subdivision thereof. Such plan shall:

(a) include a statement of project goals and objectives and a description of the services to be provided to meet such goals and objectives;

(b) identify the geographic area to be served, which may include a county, municipality or any subdivision thereof, or a combination of counties, municipalities or subdivisions thereof;

(c) identify the prevalence and incidence of adolescent pregnancy and parenting and related problems to be addressed by the project in the geographic area; and a description, by number and characteristics, of the project's target population to be served;

(d) describe the services currently available to serve the eligible adolescents which may help reinforce the goals and objectives of the community service project;

(e) describe how services for eligible adolescents will be coordinated within such project plans, and efforts to be made to improve client access to such services by improving interagency cooperation and program coordination;

(f) describe how the project funds received pursuant to this title

shall be used;

(g) describe the community's involvement in the project plan, and the involvement of relevant agencies and appropriate groups involved within such project plan;

(h) describe how the proposed services are relevant to the population being served; and

(i) describe the method to be used to evaluate and report upon the effectiveness of the community service project funded under the provisions of this title.

2. The community service project plan shall be developed by the community council which shall direct the activities of the community service project. The community council shall select a lead agency which shall be responsible for the administration of the community service project. The community council shall select and approve the funding of subcontractors pursuant to this title for the purpose of the development of the community service project plan.

§ 2515-c. Use of funds. 1. Subject to amounts made available therefor, such funds shall be made available for up to seventy-five percent of approved community service project plan expenditures after first deducting therefrom any federal or other state funds received or to be received on account thereof. The remaining twenty-five percent cost of such plan may be met by local governmental or private funds, services or property. The commissioner, within his or her discretion, may, however, waive the twenty-five percent requirement for the year if he or she determines that a plan, which otherwise meets the requirements of this title, is unable to obtain local governmental or private funding, services or property. Any such waiver shall be requested upon submittal of such plan to the commissioner. No more than five percent of the funds approved under this article shall be retained by the department for administrative and evaluation purposes.

2. Funds granted to not-for-profit corporations or governmental entities pursuant to the adolescent pregnancy prevention and services program shall not be used to supplant other federal, state or local

funds.

TITLE II
PRENATAL CARE

- Section 2522. Programs; powers of the commissioner.
2530. Nurse-family partnership.
2530-a. Payment for prenatal care special services.
2531. Children and recovering mothers program.
2532. Workgroup.

§ 2522. Programs; powers of the commissioner. In order to promote comprehensive prenatal care, the commissioner is authorized to provide funds, including the awarding of grants to not-for-profit community-based organizations, local health departments, public education organizations and such other organizations as may be designated by the commissioner, for public and provider education and outreach, home visiting, referral of pregnant women to prenatal care providers, and improvement of regional systems of perinatal care. This education, outreach, home visiting, referral and systems improvement may include, but is not limited to:

- (a) public education concerning availability of prenatal services;
- (b) promotion of community awareness of the benefits to the mother and child of preconception health and early and continuous prenatal care;
- (c) outreach and direct recruitment of service recipients and providers;
- (d) referrals and linkage to organizations providing assistance with applications for medical assistance and enrollment in Medicaid managed care programs;
- (e) referrals and linkage with home visiting and other community services;
- (e-1) health and nutritional education and services for both parents, regarding childhood and adult obesity and asthma, and the prevention or mitigation thereof;
- (f) follow-up of patient participation in prenatal care services;
- (g) identification of regional perinatal health care system barriers

and limitations that lead to poor perinatal outcomes and development of strategies to address such barriers and limitations;

(h) coordination of service delivery by community-based organizations among health care providers and health plans using health information technology and uniform screening criteria for perinatal risk; and

(i) promotion of training and continuing medical education opportunities in military cultural competency for providers of prenatal care to veterans. For purposes of this subdivision, the term "veteran" shall have the same meaning as such term is defined in section one of the veterans' services law and shall also include a veteran who has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service.

§ 2530. Nurse-family partnership. 1. The commissioner is authorized to establish, subject to federal financial participation and within amounts appropriated therefor, the nurse-family partnership program, a Medicaid program subject to title eleven of article five of the social services law, aimed at improving the health of eligible participants.

2. As used in this section, the following terms shall have the following meanings:

(a) "Eligible participant" means a person enrolled in medical assistance under title eleven of article five of the social services law who is a pregnant woman who will be a first-time mother; and her newborn, either or both of whom is at risk for poor outcomes.

"Participant" means an eligible participant who is participating in the nurse-family partnership program.

(b) "Nurse-family partnership program" or "program" means the nurse-family partnership program established under this section.

(c) "Nurse-family partnership provider" or "provider" means a county health department, including the health department of the city of New York, or an entity in contract with such a health department to provide services under the program or an entity that contracts directly with the

commissioner to provide services under this program.

(d) "Case management services" means services that assist a participant in gaining access to needed medical, social, educational, and other services, including: an assessment to determine service needs; development of a care plan based on the assessment; referral to medical, social, educational and other providers; and monitoring and other follow-up activities to ensure that the care plan is effectively implemented and addresses the assessed needs.

3. The nurse-family partnership program is a nurse home-visiting program in which a nurse-family partnership provider provides case management and nursing services (primarily nurse home visits to participants) to eligible participants up to the child's second birthday. Participation in the program shall be voluntary for eligible participants.

4. A nurse-family partnership provider shall be approved by a nationally-recognized organization involved with nurse-family partnership programs, designated by the commissioner, and shall meet such other criteria as established by the commissioner.

5. The commissioner may establish the nurse-family partnership program in one or more social services districts and may establish program enrollment limits based on analysis of need and available appropriations.

6. Nurse-family partnership program services provided by a provider to an eligible participant under this section shall be deemed to be medical assistance services under title eleven of article five of the social services law. The commissioner may establish, subject to the approval of the director of the division of the budget, rates of payment to nurse-family partnership providers for providing nurse-family partnership program services.

7. The commissioner shall submit all appropriate amendments to the state plan for medical assistance and shall submit applications for waivers of the federal social security act as shall be necessary to

obtain federal financial participation in the costs of services provided pursuant to this section.

§ 2530-a. Payment for prenatal care special services. 1. The commissioner is authorized to establish a program to provide services under title eleven or title eleven-D of article five of the social services law, for early and continuous prenatal care for pregnant women who are eligible to receive services under those titles, to prevent complications during pregnancy and childbirth and to reduce neonatal intensive care admissions (referred to in this section as the "program"). The program shall include the collection, and transmittal to the department, of health status data pertinent to the management of pregnancy risk on a health status data form established by the department.

2. The collection of data under the program shall be based on the pregnant woman's informed written consent, which shall be in a format developed by the commissioner and maintained in the provider's medical record. Participation in the program shall be voluntary for the pregnant woman. A woman's failure to give consent for the collection of data under this section or to participate in the program shall not result in the diminution of any services otherwise available under title eleven or eleven-D of article five of the social services law.

3. If consent and voluntary participation pursuant to subdivision two of this section is obtained, providers of prenatal care under title eleven or title eleven-D of article five of the social services law, shall endeavor to collect at the earliest possible prenatal visit, and report to the department in a form and manner determined by the commissioner, health status data concerning each pregnant woman eligible for services under title eleven or title eleven-D of article five of the social services law, and treated by such provider.

4. Upon receipt of a health status data form, the department shall take one of the following actions:

(a) If the pregnant woman, at the time of the receipt of the health

status data form by the department, is enrolled in a managed care health plan, the department shall send the form to the plan for triage and appropriate care management interventions, which shall include available plan services and referrals for other services available in the community.

(b) If the pregnant woman, at the time of the receipt of the health status data form by the department, is not enrolled in a managed care health plan, the department shall send the form to an entity described in subdivision five of this section for triage and appropriate care management services, which shall include, but not be limited to, needed home visits and referrals to community based services for high risk pregnant women. If the pregnant woman subsequently becomes enrolled in a managed care health plan, the designated entity and the plan shall assure continuity of care.

5. Patient health status data collected under this section shall be maintained as confidential by the department and by any person or entity to whom the department discloses the data. Such data may only be disclosed by the department under this section.

6. For purposes of the activities described in paragraph (b) of subdivision four of this section, the department is authorized to enter into agreements with and, within amounts appropriated therefor, provide funding to, local health departments or not-for-profit organizations to promote positive pregnancy outcomes, optimal child health, growth and development, and safe home environments.

7. The department is authorized to operate the program authorized by this section in a subset of counties in the state.

8. Within amounts appropriated therefor, the commissioner is authorized to develop fees to reimburse enrolled fee-for-service providers for the collection and transmittal of clinical data authorized by this section.

§ 2531. Children and recovering mothers program. Subject to

appropriation, the commissioner, in consultation with the commissioner of alcoholism and substance abuse services, is authorized to establish the children and recovering mothers program, a program aimed at providing health care providers, hospitals and midwifery birth centers with guidance, education and assistance when providing care to expectant mothers with a substance use disorder. Such program shall:

1. Provide information to both health care providers as well as expectant mothers regarding use of medication assisted treatment for pregnant women, which shall include information regarding buprenorphine training, tools for providers on effective management of women with a substance use disorder during pregnancy, and a referral list of providers in the area;
2. Provide guidance and referral information for substance use disorder services, home visiting services and other benefits and services that they may be eligible for while expecting and after birth;
3. Develop a system for rapid consultation and referral linkage services for obstetricians and primary care providers statewide who provide care for expectant mothers with substance use disorders;
4. Provide guidance on the identification of signs and symptoms of substance use disorder in expectant mothers; and
5. Anything else deemed necessary to implement the program.

§ 2532. Workgroup. The commissioner, in conjunction with the commissioner of alcoholism and substance abuse services, shall convene a workgroup of stakeholders, including but not limited to, hospitals, local health departments, obstetricians, midwives, pediatricians, and substance use disorder providers to study and evaluate barriers and challenges in identifying and treating expectant mothers, newborns and new parents with a substance use disorder. The workgroup shall report on its findings and recommendations to the commissioner, the commissioner of alcoholism and substance abuse services, the speaker of the assembly

and the temporary president of the senate within one year of the effective date of this section.

TITLE II-A

EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS WITH DISABILITIES AND THEIR FAMILIES

- Section 2540. Establishment of early intervention program.
2541. Definitions.
2542. Comprehensive child find system and public awareness program.
2543. Service coordinators.
2544. Screening and evaluations.
2545. Individualized family services plans ("IFSP").
2546. Interim services.
2547. Respite services.
- 2547-a. Day care support services.
2548. Transition plan.
2549. Due process.
2550. Responsibilities of lead agency.
2551. Coordinated standards and procedures.
2552. Responsibility of municipality.
2553. Early intervention coordinating council.
2554. Local early intervention coordinating councils.
2556. Administrative costs.
2557. Financial responsibility and reimbursement.
2558. Responsibility for certain temporary-resident infants and toddlers with disabilities.
2559. Medical assistance program payments.
- 2559-a. Transportation.
- 2559-b. Regulations.

§ 2540. Establishment of early intervention program. There is established an early intervention program under the administration of the commissioner.

§ 2541. Definitions. As used in this title the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Children at risk" means children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, as determined by the commissioner through regulation.

2. "Coordinated standards and procedures" means standards and procedures developed by state early intervention service agencies pursuant to section twenty-five hundred fifty-one of this title.

3. "Council" means the early intervention coordinating council established under section twenty-five hundred fifty-three of this title.

4. "Developmental delay" means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical, communication, social or emotional, or adaptive.

5. "Disability" means:

- (a) a developmental delay; or
- (b) a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as Down syndrome or other chromosomal abnormalities, sensory impairments, inborn errors of metabolism or fetal alcohol syndrome.

6. "Early intervention official" means an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official.

7. "Early intervention services" means developmental services that:

- (a) are provided under public supervision;

(b) are selected in collaboration with the parents;

(c) are designed to meet a child's developmental needs in any one or more of the following areas:

(i) physical development, including vision and hearing,

(ii) cognitive development,

(iii) communication development,

(iv) social or emotional development, or

(v) adaptive development;

(d) meet the coordinated standards and procedures;

(e) are provided by qualified personnel;

(f) are provided in conformity with an IFSP;

(g) are, to the maximum extent appropriate, provided in natural environments, including the home and community settings where children without disabilities would participate;

(h) include, as appropriate:

(i) family training, counseling, home visits and parent support groups,

(ii) special instruction,

(iii) speech pathology and audiology,

(iv) occupational therapy,

(v) physical therapy,

(vi) psychological services,

(vii) case management services, hereafter referred to as service coordination services,

(viii) medical services for diagnostic or evaluation purposes, subject to reasonable prior approval requirements for exceptionally expensive services, as prescribed by the commissioner,

(ix) early identification, screening, and assessment services,

(x) health services necessary to enable the infant or toddler to benefit from the other early intervention services,

(xi) nursing services,

(xii) nutrition services,

(xiii) social work services,

(xiv) vision services,

(xv) assistive technology devices and assistive technology services,

(xvi) transportation and related costs that are necessary to enable a child and the child's family to receive early intervention services, and

- (xvii) other appropriate services approved by the commissioner.
- (i) are cost-effective.

8. (a) "Eligible child" means an infant or toddler from birth through age two who has a disability; provided, however, that any toddler with a disability who has been determined to be eligible for program services under section forty-four hundred ten of the education law and:

(i) who turns three years of age on or before the thirty-first day of August shall, if requested by the parent, be eligible to receive early intervention services contained in an IFSP until the first day of September of that calendar year; or

(ii) who turns three years of age on or after the first day of September shall, if requested by the parent and if already receiving services pursuant to this title, be eligible to continue receiving such services until the second day of January of the following calendar year.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, a child who receives services pursuant to section forty-four hundred ten of the education law shall not be an eligible child.

9. "Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel and conducted pursuant to section twenty-five hundred forty-four of this title to determine a child's eligibility under this title.

10. "Evaluator" means a team of two or more professionals approved pursuant to section twenty-five hundred fifty-one of this title to conduct screenings and evaluations.

11. "IFSP" means the individualized family service plan adopted in accordance with section twenty-five hundred forty-five of this title.

12. "Lead agency" means the department of health, the public agency responsible for the administration of the early intervention system in collaboration with the state early intervention service agencies.

13. "Municipality" means a county outside the city of New York or the

city of New York in the case of a county contained within the city of New York.

13-a. Subject to federal law and regulations, "natural environment" or "natural setting" means a setting that is natural or normal for the child's age peers who have no disability.

14. "Parent" means parent or person in parental relation to the child. With respect to a child who has no parent or person in a parental relation, "parent" shall mean the person designated to serve in parental relation for the purposes of this title, pursuant to regulations of the commissioner promulgated in consultation with the commissioner of social services for children in foster care.

15. "Qualified personnel" means:

(a) persons holding a state approved or recognized certificate, license or registration in one of the following fields:

(i) special education teachers;

(ii) speech and language pathologists and audiologists;

(iii) occupational therapists;

(iv) physical therapists;

(v) social workers;

(vi) nurses;

(vii) dietitians or nutritionists;

(viii) other persons designated by the commissioner who meet requirements that apply to the area in which the person is providing early intervention services, where not in conflict with existing professional licensing, certification and/or registration requirements.

(b) persons holding a state approved license in one of the following fields:

(i) psychologists; or

(ii) physicians.

16. "Service coordinator" means a person who:

(a) meets the qualifications established in federal law and regulation and demonstrates knowledge and understanding of:

(i) infants and toddlers who may be eligible for services under this

title;

(ii) principles of family-centered services;

(iii) part H of the federal individuals with disabilities education act and its corresponding regulations;

(iv) the nature and scope of services available under this title; and

(v) the requirements for authorizing and paying for such services and other pertinent information;

(b) is responsible for:

(i) assisting eligible children and their families in gaining access to services listed on the IFSP;

(ii) coordinating early intervention services with other services such as medical and health services provided to the child;

(iii) coordinating the performance of evaluations and assessments;

(iv) participating in the development, monitoring and evaluation of the IFSP;

(v) assisting the parent in identifying available service providers;

(vi) coordinating service delivery;

(vii) informing the family of advocacy services;

(viii) where appropriate, facilitating the transition of the child to other appropriate services; and

(ix) assisting in resolving any disputes which may arise between the family and service providers, as necessary and appropriate; and

(c) meets such other standards as are specified pursuant to section twenty-five hundred fifty-one of this title.

17. "State early intervention service agencies" means the departments of health, education and social services and the offices of mental health and alcoholism and substance abuse services and the office for people with developmental disabilities.

18. "Year" shall mean the twelve-month period commencing July first unless otherwise specified.

§ 2542. Comprehensive child find system and public awareness program.

1. The commissioner shall develop a comprehensive child find system that ensures that eligible children in the state are identified, located,

referred to the early intervention official and evaluated. Such system shall:

(a) require early intervention officials to identify and locate eligible children within their municipality;

(b) be coordinated with efforts to identify, locate and track children conducted by other agencies responsible for services to infants and toddlers and their families, including the efforts in (i) part B of the federal individuals with disabilities education act, including early childhood direction centers, (ii) the maternal and child health program under title V of the federal social security act, including the infant health assessment program, (iii) medicaid's early periodic screening, diagnosis and treatment program under title XIX of the federal social security act, and (iv) the federal supplemental security income program; and

(c) provide for the identification, tracking and screening of children at risk of developmental delay, using resources available through the programs, identified in paragraph (b) of this subdivision and such other available resources as the commissioner shall commit to this purpose.

2. The commissioner shall develop, implement, and maintain a public awareness program to inform the general public and the professional community of the availability of the early intervention program and the benefits of services to infants and toddlers with disabilities and their families. The program shall include materials which describe the normal developmental achievements of young children, identification and procedures for referral of children with disabilities, and how to gain access to early intervention services.

3. The following persons and entities, within two working days of identifying an infant or toddler suspected of having a disability or at risk of having a disability, shall refer such infant or toddler to the early intervention official or the health officer of the public health district in which the infant or toddler resides, as designated by the municipality, but in no event over the objection of the parent made in accordance with procedures established by the department for use by such primary referral sources, unless the child has already been referred: hospitals, child health care providers, day care programs, local school

districts, public health facilities, early childhood direction centers and such other social service and health care agencies and providers as the commissioner shall specify in regulation; provided, however, that the department shall establish procedures, including regulations if required, to ensure that primary referral sources adequately inform the parent or guardian about the early intervention program, including through brochures and written materials created or approved by the department.

4. The commissioner shall provide each early intervention official with a list of all approved evaluators and service coordinators in the municipality or geographic area proximate to such municipality or, with respect to the city of New York, subdivisions of the city as prescribed by the commissioner.

Such list of approved evaluators shall be updated at least annually and shall describe the specific areas of expertise of each qualified evaluator, if known.

§ 2543. Service coordinators. 1. Upon referral to the early intervention official of a child thought to be an eligible child by a parent or professional, the early intervention official shall promptly designate an initial service coordinator, selecting whenever appropriate a service coordinator who has an established relationship with the child or family, and shall promptly notify the parent of such designation.

2. The initial service coordinator shall promptly arrange a contact with the parent after such designation, provided that such contact must be in a time, place and manner reasonably convenient for the parent and consistent with the timeliness requirements of this title.

§ 2544. Screening and evaluations. 1. Each child thought to be an eligible child is entitled to a multidisciplinary evaluation, and the early intervention official shall ensure such evaluation, with parental consent.

2. (a) The parent may select an evaluator from the list of approved evaluators as described in section twenty-five hundred forty-two of this title to conduct the evaluation. The parent or evaluator shall immediately notify the early intervention official of such selection. The evaluator may begin the evaluation no sooner than four working days after such notification, unless otherwise approved by the initial service coordinator.

(b) the evaluator shall designate an individual as the principal contact for the multidisciplinary team.

(c) If, in consultation with the evaluator, the service coordinator identifies a child that is potentially eligible for programs or services offered by or under the auspices of the office for people with developmental disabilities, the service coordinator shall, with parent consent, notify the office for people with developmental disabilities' regional developmental disabilities services office of the potential eligibility of such child for said programs or services.

3. (a) To determine eligibility, an evaluator shall, with parental consent, either (i) screen a child to determine what type of evaluation, if any, is warranted, or (ii) provide a multidisciplinary evaluation. In making the determination whether to provide an evaluation, the evaluator may rely on a recommendation from a physician or other qualified person as designated by the commissioner.

(b) If, based upon the screening, a child is believed to be eligible, or if otherwise elected by the parent, the child shall, with the consent of a parent, receive a multidisciplinary evaluation. All evaluations shall be conducted in accordance with the coordinated standards and procedures and with regulations promulgated by the commissioner.

4. The evaluation of each child shall:

(a) be conducted by personnel trained to utilize appropriate methods and procedures;

(b) be based on informed clinical opinion;

(c) be made without regard to the availability of services in the municipality or who might provide such services; and

(d) with parental consent, include the following:

(i) a review of pertinent records related to the child's current health status and medical history;

(ii) an evaluation of the child's level of functioning in each of the developmental areas set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title;

(iii) an assessment of the unique needs of the child in terms of each of the developmental areas set forth in paragraph (c) of subdivision seven of section twenty-five hundred forty-one of this title, including the identification of services appropriate to meet those needs;

(iv) an evaluation of the transportation needs of the child, if any; and

(v) such other matters as the commissioner may prescribe in regulation.

5. An evaluation shall not include a reference to any specific provider of early intervention services.

6. Nothing in this section shall restrict an evaluator from utilizing, in addition to findings from his or her personal examination, other examinations, evaluations or assessments conducted for such child, including those conducted prior to the evaluation under this section, if such examinations, evaluations or assessments are consistent with the coordinated standards and procedures.

7. Following completion of the evaluation, the evaluator shall provide the parent and service coordinator with a copy of a summary of the full evaluation. To the extent practicable, the summary shall be provided in the native language of the parent. Upon request of the parent, early intervention official or service coordinator, the evaluator shall provide a copy of the full evaluation to such parent, early intervention official or service coordinator.

8. A parent who disagrees with the results of an evaluation may obtain an additional evaluation or partial evaluation at public expense to the extent authorized by federal law or regulation.

9. Upon receipt of the results of an evaluation, a service coordinator

may, with parental consent, require additional diagnostic information regarding the condition of the child, provided, however, that such evaluation or assessment is not unnecessarily duplicative or invasive to the child, and provided further, that:

(a) where the evaluation has established the child's eligibility, such additional diagnostic information shall be used solely to provide additional information to the parent and service coordinator regarding the child's need for services and cannot be a basis for refuting eligibility;

(b) the service coordinator provides the parent with a written explanation of the basis for requiring additional diagnostic information;

(c) the additional diagnostic procedures are at no expense to the parent; and

(d) the evaluation is completed and a meeting to develop an IFSP is held within the time prescribed in subdivision one of section twenty-five hundred forty-five of this title.

10. (a) If the screening indicates that the infant or toddler is not an eligible child and the parent elects not to have an evaluation, or if the evaluation indicates that the infant or toddler is not an eligible child, the service coordinator shall inform the parent of other programs or services that may benefit such child, and the child's family and, with parental consent, refer such child to such programs or services.

(b) A parent may appeal a determination that a child is ineligible pursuant to the provisions of section twenty-five hundred forty-nine of this title, provided, however, that a parent may not initiate such appeal until all evaluations are completed.

11. Notwithstanding any other provision of law to the contrary, where a request has been made to review an IFSP prior to the six-month interval provided in subdivision seven of section twenty-five hundred forty-five of this title for purposes of increasing frequency or duration of an approved service, including service coordination, the early intervention official may require an additional evaluation or partial evaluation at public expense by an approved evaluator other than the current provider of service, with parent consent.

§ 2545. Individualized family services plans ("IFSP"). 1. If the evaluator determines that the infant or toddler is an eligible child, the early intervention official shall convene a meeting, at a time and place convenient to the parent, consisting of the parent, such official, the evaluator, the initial service coordinator and any other persons who the parent or the initial service coordinator, with the parent's consent, invite, provided that such meeting shall be held no later than forty-five days from the date that the early intervention official was first contacted regarding the child, except under exceptional circumstances prescribed by the commissioner. The early intervention official, at or prior to the time of scheduling the meeting, shall inform the parent of the right to invite any person to the meeting.

2. The early intervention official, initial service coordinator, parent and evaluator shall develop an IFSP for an eligible child whose parents request services. The IFSP shall be in writing and shall include, but not be limited to:

(a) a statement, based on objective criteria, of the infant's or toddler's present levels of physical development, including vision and hearing; cognitive development; communication development; social or emotional development; and adaptive development;

(b) with parental consent, a statement of the family's strengths, priorities and concerns that relate to enhancing the development of the infant or toddler;

(c) a statement of (i) the major outcomes expected to be achieved for the child and the family, including timelines, and (ii) the criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;

(d) a statement of specific early intervention services, including transportation and the mode thereof, necessary to meet the unique needs of the child and the family, including the frequency, intensity, location and the method of delivering services;

(e) a statement of the natural environments, including the home and community settings where children without disabilities participate, in

which early intervention services shall appropriately be provided and an explanation of their appropriateness, and, where the child is in day care, a plan for qualified professionals to train the day care provider to accommodate the needs of the child, where appropriate;

(f) a statement of other services, including but not limited to medical services, that are not required under this title but that are needed by the child and the family;

(g) a statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated;

(h) the projected dates for initiation of services and the anticipated duration of such services;

(i) the name of the service coordinator selected by the parent who will be responsible for the implementation of the IFSP and coordination with other agencies and persons;

(j) the steps to be taken supporting the potential transition of the toddler with a disability to services provided under section forty-four hundred ten of the education law or to other services, to the extent the child is thought to be eligible for such services, including:

(i) discussions with and education of parents regarding potential options and other matters related to the child's transition;

(ii) procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting; and

(iii) with parental consent, the transmission of information about the child to the committee on preschool special education, to ensure continuity of services, if appropriate, including evaluation and assessment information and copies of IFSPs.

3. In developing the IFSP, consideration shall first be given to provision of transportation by a parent of a child to early intervention services. Other modes of transportation shall be provided if the parent can demonstrate the inability to provide appropriate transportation services.

4. If the IFSP team members, including the early intervention official and the parent agree on the IFSP, the IFSP shall be deemed final and the service coordinator shall be authorized to implement the plan.

5. If the IFSP team members, including the early intervention official and the parent do not agree on an IFSP, the service coordinator shall implement the sections of the proposed IFSP that are not in dispute, and the parent shall have the due process rights set forth in section twenty-five hundred forty-nine of this title.

6. The contents of the IFSP shall be fully explained to the parent, and informed consent from the parent shall be obtained prior to the provision of the early intervention services therein. If the parent does not provide such consent with respect to a particular early intervention service, then only those early intervention services with respect to which consent is obtained shall be provided.

7. The IFSP shall be reviewed at six month intervals and shall be evaluated annually by the early intervention official, service coordinator, the parent and providers of services to the eligible child. Upon request of a parent, the plan may be reviewed by such persons at more frequent intervals.

8. If, at any time, the parent and the service coordinator agree, in writing, that the child has met all the goals set forth in the IFSP or is otherwise no longer in need of services pursuant to this article, the service coordinator shall certify that the child is no longer an eligible child.

9. A parent may, at any time during or after development of the IFSP, select a service coordinator who will become responsible for implementing the IFSP and who may be different from the initial service coordinator.

10. The service coordinator shall ensure that the IFSP, including any amendments thereto, is implemented in a timely manner but not later than thirty days after the projected dates for initiation of the services as set forth in the plan.

§ 2546. Interim services. 1. Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment in sections twenty-five hundred forty-four and twenty-five hundred forty-five of this title, if the following conditions are met:

(a) Parental consent is obtained;

(b) An interim IFSP is developed that includes: (i) the name of a service coordinator who will be responsible for implementation of the interim IFSP and coordination with other agencies and persons; and (ii) the early intervention services that have been determined to be needed immediately by the child and the child's family; and

(c) The evaluation and assessment are completed within forty-five days from the date the early intervention official was first contacted regarding the child.

2. The costs that an approved provider of early intervention services incurs in providing such interim services shall be approved costs to the extent they are otherwise consistent with section twenty-five hundred fifty-five of this title.

§ 2547. Respite services. 1. Subject to the availability of federal funds, the commissioner shall allocate a portion of such funds for respite services for families of eligible children. The commissioner shall establish criteria for selecting families for such services, which may include the severity of the child's disability, the availability of respite services to the family through other programs, and the availability of informal supports to the family.

2. In addition to respite services provided pursuant to subdivision one of this section and subject to the amounts appropriated therefor, the state shall reimburse the municipality in accordance with the percentage of state aid reimbursement for approved costs as set forth in subdivision two of section twenty-five hundred fifty-seven of this title, for the costs of respite services provided to eligible children and their families with the approval of the early intervention official.

3. The commissioner shall contact the appropriate federal governmental agencies and personnel to facilitate the availability of federal funds for respite services.

§ 2547-a. Day care support services. The commissioner shall allocate up to one million dollars of federal funds for purposes of establishing two or more demonstration programs for the provision of day care support services for eligible children which may include the use of paraprofessionals to work with one or more children with disabilities within the same setting. The commissioner, in consultation with other appropriate state agencies, shall establish criteria for the selection of demonstration sites for such services, such criteria to include, but not be limited to, geographic distribution, the disability severity of children to be served by such a program and the availability of similar services from other sources.

§ 2548. Transition plan. To the extent that a toddler with a disability is thought to be eligible for services pursuant to section forty-four hundred ten of the education law, the service coordinator shall notify in writing the committee on preschool special education of the local school district in which an eligible child resides of the potential transition of such child and, with parental consent, arrange for a conference among the service coordinator, the parent and the chairperson of the preschool committee on special education or his or her designee at least ninety days before such child would be eligible for services under section forty-four hundred ten of the education law to review the child's program options and to establish a transition plan, if appropriate. If a parent does not consent to a conference with the service coordinator and the chairperson of the preschool committee on special education or his or her designee to determine whether the child should be referred for services under section forty-four hundred ten of the education law, and the child is not determined to be eligible by the committee on preschool special education for such services prior to the child's third birthday, the child's eligibility for early intervention program services shall end at the child's third birthday.

§ 2549. Due process. 1. If a parent disagrees with the determination of the evaluator or the local early intervention official with regard to the eligibility for or provision of early intervention services or if such official fails to act within such period of time as may be required by this title or regulations of the commissioner, a parent may make a request in writing for mediation or an impartial hearing to resolve the dispute; provided, however, if a parent elects not to pursue mediation, such election shall not (a) preclude a parent from requesting an impartial hearing or (b) constitute a failure to exhaust administrative remedies.

2. A request for mediation shall be made to the early intervention official for the municipality in which the child resides. Upon such request, the municipality shall notify a community dispute resolution center designated by the commissioner to provide mediation services for such municipality. The community dispute resolution center shall arrange for the mediation to be conducted at a place and time convenient to the parent. Such mediation shall be at no cost to the parent. If all parties agree to the terms of a mediation agreement, a copy of such agreement shall be forwarded by the community dispute resolution center to the participating parties and the service coordinator who shall incorporate the provisions of such agreement into the IFSP no later than five days after receiving a copy of such agreement. If the parties are unable to reach agreement, in full or in part, the mediator shall inform the parent of the availability of the impartial hearing procedures.

3. A parent may file a written request at any time for an impartial hearing with the commissioner or a designee provided, however, that a request for a hearing to contest a determination that a child is not eligible for services under this title must be made within six months of such determination. Upon receipt of such request, the commissioner, or the designee, shall promptly notify the parent, or a person designated by the parent, and other appropriate parties in accordance with the regulations of the commissioner. Any such notice to the parent shall be provided in the native language of such person whenever practicable and,

if not, in a manner to ensure notice to such person and shall include but not be limited to:

- (a) the procedural safeguards afforded to a parent;
- (b) the date, time and location for the impartial hearing, which shall be reasonably convenient for the parent;
- (c) the procedures for the appointment of an impartial hearing officer; and
- (d) the right of the parent to appeal the decision of the impartial hearing to a court of competent jurisdiction.

4. After receipt of notice from the commissioner of a parent's request for an impartial hearing, the early intervention official shall promptly notify the parent as to whether the municipality intends to be represented by an attorney at such hearing.

5. The impartial hearing shall be conducted by the hearing officer in accordance with the regulations of the commissioner. The hearing shall be held, and a decision rendered, within thirty days after the department receives the request for an impartial hearing except to the extent that the parent consents, in writing, to an extension. The decision shall be in writing and shall state the reasons for the decision and shall be final unless appealed by a party to the proceeding. A copy of the decision reached by the hearing officer shall be mailed to the parent, any public or private agency that was a party to the hearing, the service coordinator, the department and any state early intervention service agency with an interest in the decision. Where ordered by the hearing officer, the service coordinator shall modify the IFSP in accordance with the decision within five days after such decision.

6. During the pendency of any mediation or impartial hearing conducted pursuant to this section, the child and family shall, with parental consent, receive those early intervention services that are not in dispute or that are provided pursuant to the IFSP previously in effect.

7. (a) All orders or determinations made hereunder shall be subject to review as provided for in article seventy-eight of the civil practice

law and rules. In any proceeding under article seventy-eight of the civil practice law and rules, the court may grant any relief authorized by the provisions of section seventy-eight hundred six of such law and rules and also may, in its discretion, remand the proceedings to the department for further consideration upon a finding that any relevant and material evidence is then available which was not previously considered by the department.

(b) A parent who, after completing mediation, substantially prevails in an impartial hearing or a judicial challenge to an order or determination under this title shall be entitled to reimbursement for reasonable attorney's fees incurred in such impartial hearing or judicial challenge provided, however, that the parent shall only be entitled to reimbursement for such fees for prevailing in an impartial hearing if the municipality was represented by an attorney at such impartial hearing.

8. (a) The early intervention official shall maintain the confidentiality of all personally identifiable information regarding the children and families receiving early intervention services. The early intervention official shall ensure that no information regarding the conditions, services, needs, or other individual information regarding a child and family is communicated to any parties other than the service coordinator and service providers currently serving the child and family, without the express written consent of the parent.

(b) Providers of service to eligible children and families shall maintain the confidentiality of all personally identifiable information regarding children and families receiving their services. The provider shall ensure that no information regarding the condition, services, needs, or any other individual information regarding a child and family is released to any party other than the early intervention official without the express written consent of the parent, except as specifically permitted in the coordinated standards and procedures, which shall additionally ensure that the requirements of federal or state law which pertain to the early intervention services of the state early intervention service agencies have been maintained.

(c) This section shall not prohibit disclosure otherwise required by law.

§ 2550. Responsibilities of lead agency. 1. The lead agency is responsible for the general administration and supervision of programs and activities receiving assistance under this title, and the monitoring of programs and activities used by the state to carry out this title, whether or not such programs or activities are receiving assistance made available under this title, to ensure that the state complies with the provisions of this title.

2. In meeting the requirements of subdivision one of this section, the lead agency shall adopt and use proper methods of administering the early intervention program, including:

(a) establishing standards for evaluators, service coordinators and providers of early intervention services;

(b) approving, and periodically re-approving evaluators, service coordinators and providers of early intervention services who meet department standards; provided however that the department may require that approved evaluators, service coordinators and providers of early intervention services enter into agreements with the department in order to conduct evaluations or render service coordination or early intervention services in the early intervention program. Such agreements shall set forth the terms and conditions of participation in the program. If the department requires that such providers enter into agreements with the department for participation in the program, "approval" or "approved" as used in this title shall mean a provider who is approved by the department in accordance with department regulations and has entered into an agreement with the department for the provision of evaluations, service coordination or early intervention services. The department shall use best efforts to ensure provider capacity in the early intervention program.

(c) monitoring of agencies, institutions and organizations under this title and agencies, institutions and organizations providing early intervention services which are under the jurisdiction of a state early intervention service agency;

(d) enforcing any obligations imposed on those agencies under this title or Part H of the federal individuals with disabilities education

act and its regulations;

(e) providing training and technical assistance to those agencies, institutions and organizations, including initial and ongoing training and technical assistance to municipalities to help enable them to identify, locate and evaluate eligible children, develop IFSPs, ensure the provision of appropriate early intervention services, promote the development of new services, where there is a demonstrated need for such services and afford procedural safeguards to infants and toddlers and their families;

(f) correcting deficiencies that are identified through monitoring; and

(g) in monitoring early intervention services, the commissioner shall provide municipalities with the results of any review of early intervention services undertaken and shall provide the municipalities with the opportunity to comment thereon.

3. The commissioner, through a comprehensive system of personnel development, shall promote the availability of qualified personnel to provide evaluations and early intervention services to eligible children and their families.

§ 2551. Coordinated standards and procedures. 1. The state early intervention service agencies shall jointly establish coordinated standards and procedures for:

(a) early intervention services and evaluations;

(b) child find system and public awareness program; and

(c) programs and services, operating under the approval authority of any state early intervention service agency, which include any early intervention services or evaluations.

2. Such coordinated standards and procedures shall be designed to:

(a) enhance the objectives of this title, including the provision of services in natural environments to the maximum extent possible;

(b) minimize duplicative and inconsistent regulations and practices among the state early intervention service agencies;

(c) conform, to the extent appropriate, to existing standards and

procedures of state early intervention service agencies; and

(d) ensure that persons who provide early intervention services are trained, or can demonstrate proficiency in principles of early childhood development.

3. Coordinated standards and procedures may include guidelines suggesting appropriate early intervention services for enumerated disabilities that are most frequently found in eligible children.

4. Coordinated standards and procedures may encompass or allow for agreements among two or more such agencies.

5. Any standards promulgated by regulation or otherwise by any state early intervention service agency governing early intervention services or evaluations shall be consistent with the coordinated standards and procedures.

6. In the event of an inability to agree upon any coordinated standard or procedure, any state early intervention service agency may refer the issue to the early intervention coordinating council for its advice with respect to the standard or procedure which the council shall provide to the early intervention service agencies affected by the issue. The commissioner, after obtaining such advice, shall adopt an appropriate standard or procedure, provided however, that the commissioner may adopt an interim standard or procedure while awaiting such advice.

7. The early intervention service agencies, in consultation with the director of the budget, shall, where appropriate, require as a condition of approval that evaluators and providers of early intervention services participate in the medical assistance program.

8. The coordinated standards and procedures shall permit such evaluators and providers of services to rely on subcontracts or other written agreements with qualified professionals, or agencies employing such professionals, provided that such professionals perform their responsibilities in conformance with regulations of the commissioner and that providers and evaluators fully disclose any such arrangements,

including any financial or personal interests, on all applications for approval.

9. Coordinated standards and procedures may identify circumstances and procedures under which an evaluator or service provider may be disqualified under this title, including procedures whereby a municipality may request such disqualification.

§ 2552. Responsibility of municipality. 1. Each municipality shall be responsible for ensuring that the early intervention services contained in an IFSP are provided to eligible children and their families who reside in such municipality. A municipality may monitor, which may include site visitation, evaluators and providers of such services within the municipality in accordance with this title and regulations promulgated hereunder, including making the determinations specified in this section. The service coordinator shall report, in a manner and format as determined by the municipality, on the delivery of services to an eligible child in accordance with the eligible child's IFSP. A municipality may request that the parent select a new service coordinator or require that the service coordinator select a new provider of services if the municipality finds that the service coordinator has not been performing his or her responsibilities as required by this title or that services have not been provided in accordance with the eligible child's IFSP. If the early intervention official determines that the evaluator has not followed the requirements in this title or regulations promulgated hereunder, the early intervention official may require that the evaluator immediately submit additional documentation to support the eligibility determination. If the evaluator does not provide the requested documentation, or the documentation provided continues to be inconsistent with the requirements of this title or regulations, the early intervention official can require that the parent select another evaluator to conduct a multidisciplinary evaluation to determine whether the child meets eligibility for program services.

2. The early intervention official shall require an eligible child's

parent to furnish the parents' and eligible child's social security numbers for the purpose of the department's and municipality's administration of the program.

§ 2553. Early intervention coordinating council. 1. (a) The department shall establish an early intervention coordinating council.

(b) The council shall consist of thirty members, unless otherwise required by federal law, appointed by the governor. At least five members shall be parents, four of whom shall be parents of children with disabilities aged twelve or younger and one of whom shall be the parent of a child with disabilities aged six or younger; at least five shall be representatives of public or private providers of early intervention services; at least one shall be involved in personnel preparation or training; at least three shall be representatives of managed care plans or managed care plan trade associations familiar with how claims for services provided pursuant to this title are managed; at least two shall be early intervention officials; at least two shall be members of the legislature or such members' designees; seven shall be the commissioner and the commissioners of education, the office of children and family services, people with developmental disabilities, mental health, alcoholism and substance abuse services and the superintendent of financial services, or their appropriate designees with sufficient authority to engage in policy planning and implementation on behalf of their agencies.

(c) The governor shall appoint ten members on the recommendation of the temporary president of the senate and the speaker of the assembly, each of whom shall recommend five members as follows: one parent of a child with disabilities age twelve or younger; one representative of public or private providers of early intervention services; one representative of a managed care plan or managed care plan trade association familiar with how claims for services provided pursuant to this title are managed; one member of the legislature; and one early intervention official. The governor shall appoint four members on the recommendations of the minority leader of the assembly and the minority leader of the senate, each of whom shall recommend two members as follows: one parent of a child with disabilities age twelve or younger;

one representative of public or private providers of early intervention services.

(d) The governor shall designate a chairperson from among the members of the council. All members shall serve for terms of three years. Such terms shall be established so that the terms of no more than one-third of the members of the council expire each year.

(e) A majority of the appointed voting membership of the council shall constitute a quorum.

2. The council shall:

(a) assist the lead agency in the effective performance of the lead agency's responsibilities set out under this title, including:

(i) identifying the sources of fiscal support for early intervention services and programs, assignment of financial responsibility to the appropriate agency and promotion of interagency agreements;

(ii) preparing applications and amendments required pursuant to federal law;

(iii) advising and assisting the commissioner regarding payment methodologies established pursuant to section twenty-five hundred fifty-five of this title to reimburse adequately the cost of services authorized pursuant to this article and to promote the efficient, economical, productive and stable delivery of early intervention services. The council shall convene a reimbursement advisory panel, the members of which shall be appointed by the commissioner, to assist the council regarding such payment methodologies. Such panel shall consist of no more than sixteen members, and shall include at least four representatives of municipalities, at least four representatives of statewide and regional provider organizations, and such other members as the commissioner shall deem appropriate.

(b) advise and assist the commissioner and other state early intervention service agencies in the development of coordinated standards and procedures pursuant to section twenty-five hundred fifty-one of this title in order to promote the full participation and cooperation of such agencies;

(c) advise and assist the commissioner and the commissioner of education regarding the transition of toddlers with disabilities to services provided under section forty-four hundred ten of the education

law, to the extent such services are appropriate;

(d) advise and assist the commissioner in identifying barriers that impede timely and effective service delivery, including advice and assistance with regard to interagency disputes; and

(e) prepare and submit an annual report to the governor and legislature on the status of the early intervention program.

3. The council shall meet at least four times a year. Special meetings may be called by the chairperson and shall be called at the request of the commissioner.

4. At least sixty days prior to the commissioner's final approval of rules and regulations pursuant to this title, other than emergency rules and regulations, the commissioner shall submit proposed rules and regulations to the council for its review. The council shall review all proposed rules and regulations and report its recommendations thereon to the commissioner within sixty days. The commissioner shall not act in a manner inconsistent with the recommendations of the council without first providing the reasons therefor. The council, upon a majority vote of its members, may require that an alternative approach to the proposed rules and regulations be published with a notice of the proposed rules and regulations pursuant to section two hundred two of the state administrative procedure act. When an alternative approach is published pursuant to this section, the commissioner shall state the reasons for not selecting such alternative approach.

5. The members of the council shall be allowed their reasonable and necessary expenses incurred in the performance of their duties hereunder.

§ 2554. Local early intervention coordinating councils. 1. A local early intervention coordinating council shall be established in each municipality. The council shall consist of members appointed by the early intervention official. At least four members of each council shall be parents of infants or toddlers with disabilities or of children aged three through twelve with disabilities. Each council shall also include

at least three public or private providers of early intervention services, at least one child care provider or representative of child care providers, the chief executive officers or their designees of the municipality's departments of social services, health and mental hygiene, a representative from the local developmental disabilities services office and a representative from one or more committees on preschool special education of local school districts in the municipality. A local body which has been previously constituted may serve this purpose if it has the appropriate members. The commissioner, in his or her discretion, may waive one or more of the foregoing membership composition requirements in those municipalities where such requirements cannot reasonably be met.

2. The local early intervention coordinating council shall meet, in open forum, at least four times a year for its first two years of existence.

3. The council shall advise the early intervention official regarding:

(a) the planning for, delivery and assessment of the early intervention services for eligible children and their families, including the transition from early intervention services to services and programs under section forty-four hundred ten of the education law and other early childhood programs;

(b) the identification of service delivery reforms needed to promote the availability of early intervention services within natural environments;

(c) the coordination of public and private agencies; and

(d) such other matters relating to early intervention policies and procedures within the municipality as are brought to its attention by parents, providers, public agencies or others.

4. The council will report annually to the early intervention official on the adequacy of the early intervention system to ensure the availability of family centered, coordinated services; and interface with other existing planning bodies that serve like populations.

§ 2556. Administrative costs. On or after July first, nineteen hundred ninety-four, and annually thereafter, municipalities shall be eligible for reimbursement for administrative costs exclusive of due process costs incurred during the preceding year pursuant to this title. Such reimbursement shall be made in the first instance from any federal funds available for such purpose, as determined by the commissioner. To the extent that such federal funds are not sufficient or available to reimburse a municipality for such administrative costs, reimbursement shall be made with state funds in an amount up to, but not exceeding, one hundred dollars for each eligible child served in such preceding year.

§ 2557. Financial responsibility and reimbursement. 1. The approved costs for an eligible child who receives an evaluation and early intervention services pursuant to this title shall be a charge upon the municipality wherein the eligible child resides or, where the services are covered by the medical assistance program, upon the social services district of fiscal responsibility with respect to those eligible children who are also eligible for medical assistance. All approved costs shall be paid in the first instance and at least quarterly by the appropriate governing body or officer of the municipality upon vouchers presented and audited in the same manner as the case of other claims against the municipality. Notwithstanding the insurance law or regulations thereunder relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to this title. Notwithstanding the insurance law or any other law or agreement to the contrary, benefits under this title shall be considered secondary to the medical assistance program under which an eligible child may have coverage.

2. The department shall reimburse the approved costs paid by a municipality for the purposes of this title, other than those reimbursable by the medical assistance program, in an amount of fifty percent of the amount expended in accordance with the rules and regulations of the commissioner; provided, however, that in the discretion of the department and with the approval of the director of

the division of the budget, the department may reimburse municipalities in an amount greater than fifty percent of the amount expended. Such state reimbursement to the municipality shall not be paid prior to April first of the year in which the approved costs are paid by the municipality, provided, however that, subject to the approval of the director of the budget, the department may pay such state aid reimbursement to the municipality prior to such date.

3. The department may perform audits, which may include site visitation, to all or any of the following: municipalities; service coordinators; evaluators or providers of early intervention services. The department shall provide the municipalities with a copy of the findings of such audits. Early intervention program state aid reimbursement or portion thereof may be withheld if, on post-audit and review, the commissioner finds that the early intervention services were not provided or those provided were not in substantial conformance with the rules and regulations established by the commissioner or that the recipient of such services was not an eligible child as defined in section twenty-five hundred forty-one of this title. In the event that the commissioner determines that there may be a withholding of state reimbursement to any municipality under this section, he shall inform the state early intervention coordinating council and the relevant local early intervention coordinating council and shall consider alternative courses of action recommended within sixty days by either body prior to withholding state reimbursement.

3-a. Each municipality may perform an audit, which may include site visitation, of evaluators and providers of such services within its municipality in accordance with standards established by the commissioner. The municipality shall submit the results of any such audit to the commissioner for review and, if warranted, adjustments in state aid reimbursement pursuant to subdivision three of this section, as well as for recovery by the municipality of its share of any disallowances identified in such audit.

5. (a) The commissioner, in his or her discretion, is authorized to contract with one or more entities to act as the fiscal agent for the

department and municipalities with respect to fiscal management and payment of early intervention claims. Municipalities shall grant sufficient authority to the fiscal agent to act on their behalf. Municipalities, and individual and agency providers as defined by the commissioner in regulation shall utilize such fiscal agent for payment of early intervention claims as determined by the department and shall provide such information and documentation as required by the department and necessary for the fiscal agent to carry out its duties.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, the commissioner is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a competitive bid or request for proposal process, provided, however, that:

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

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

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

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

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

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

(iii) The commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

(c) Paragraph (b) of this subdivision shall apply only to the initial contract or contracts necessary to obtain the services of a fiscal agent for early intervention program fiscal management and payment of early intervention claims and shall not apply to subsequent contracts needed to maintain such services, as determined by the commissioner in his or her discretion.

§ 2558. Responsibility for certain temporary-resident infants and toddlers with disabilities. 1. Definitions. In addition to the definitions contained in section twenty-five hundred forty-one of this title, the following terms shall have the following meanings:

(a) "Foster child" shall mean a child in the care, custody or guardianship of a commissioner of a local social services district.

(b) "Homeless child" shall mean a child placed in a hotel, motel, shelter, or other temporary housing arrangement by a social services district because of the unavailability of permanent housing.

(c) "Municipality of current location" shall mean a municipality in which a child lives which is different from the municipality in which a child or such child's family lived at the time a social services district assumed responsibility for the placement of such child or family or at the time the child was admitted for care or treatment in a facility licensed or operated by another state agency.

(d) "Municipality of residence" shall mean the municipality in which a child or such child's family lived at the time the local social services district assumed responsibility or custody for such child or family or at the time the child was admitted for care or treatment in a facility licensed or operated by another state agency.

(e) "Child in residential care" shall mean an infant or toddler living in a residential facility licensed or operated by a state agency. For the purposes of subdivisions two, three and four of this section, a child in residential care shall be deemed to be a homeless child.

2. Evaluation and IFSP responsibility. The municipality of current location of a foster child or homeless child shall be responsible for the evaluation and IFSP procedures prescribed for an infant or toddler suspected of having a disability. The municipality of current location shall identify to the commissioner each eligible foster child or homeless child, and the municipality of current location of such child shall also transmit a copy of the IFSP and cost of service of such child to the municipality of residence.

3. Contract and payment responsibility. The municipality of current

location shall be the municipality of record for an eligible foster child or homeless child for the purposes of this title, provided that notwithstanding the provision of subdivision two of section twenty-five hundred fifty-seven of this title, the state shall reimburse one hundred percent of the approved costs paid by such municipality which shall be offset by the local contribution due pursuant to subdivision four of this section.

4. Local contribution. The municipality of residence shall be financially responsible for the local contribution in the amount of fifty percent of the amount expended provided, however, that in the discretion of the department and with the approval of the director of the division of the budget, in accordance with subdivision two of section twenty-five hundred fifty-seven of this title, the department may require that municipalities be financially responsible for a local contribution in an amount less than fifty percent of the amount expended. The commissioner shall certify to the comptroller the amount of the local contribution owed by each municipality to the state. The comptroller shall deduct the amount of such local contribution first from any moneys due the municipality pursuant to section twenty-five hundred fifty-six of this title and then from any other moneys due or to become due to the municipality.

§ 2559. Medical assistance program payments. 1. Nothing in this title shall be construed to permit the department or any other state agency or municipality to reduce medical assistance or other assistance or services available to eligible children.

2. Notwithstanding any other provisions of law, costs incurred for early intervention services that otherwise qualify as medical assistance that are furnished to an eligible child who is also eligible for benefits pursuant to title eleven of article five of the social services law are considered to be medical assistance for purposes of payments to providers and state reimbursement to the extent that federal financial participation is available therefor.

3. (a) Parents shall provide the municipality and the service coordinator with a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of early intervention services.

(b) Providers shall utilize the department's fiscal agent and data system for claiming payment for evaluations and services rendered under the early intervention program.

(c) A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from the medical assistance program. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided prior to receipt of written notice of the exercise of subrogation rights. Notwithstanding any inconsistent provision of this title, except as provided for herein, no third party payor other than the medical assistance program shall be required to reimburse for early intervention services provided under this title.

4. Notwithstanding any other provision of law, the commissioner, pursuant to a memorandum of understanding with the commissioner of the office for people with developmental disabilities, shall develop and submit a medicaid home and community based services waiver, pursuant to section 1915c of the social security act, for the purpose of creating a waiver program to provide and finance services for children who qualify for the early intervention program. In further establishing eligibility criteria under the waiver program, the commissioner, in conjunction with the commissioner of the office for people with developmental disabilities, shall establish health, developmental and psycho-social criteria which shall permit the broadest eligibility based on criteria for the early intervention program and federal standards for participation in a waiver program. The waiver application shall be submitted pursuant to section 1915c of the social security act no later than January first, two thousand four.

5. Notwithstanding any law to the contrary, there is hereby established an early intervention demonstration project to be conducted in Albany, Montgomery, Rensselaer, Saratoga and Schenectady Counties. Such project shall be for the purposes of facilitating coverage eligibility determinations and claims submissions for early intervention services. The commissioner is hereby authorized and directed to facilitate and, within the amounts appropriated, shall award grant funds for the implementation and operation of such demonstration project which shall be conducted by an association representative of health maintenance organizations licensed under article forty-four of this chapter and article forty-three of the insurance law in conjunction with the commissioner and the counties specified in this subdivision.

Such demonstration shall include the development of an integrated web portal enabling access to health plan data bases to facilitate coverage eligibility, benefit determinations and claims submission and processing. Such access shall be subject to all federal and state laws for the confidentiality of personal and medical record information. The demonstration will develop technology solutions to facilitate coverage determinations and streamline and monitor claims processes and payment.

The association conducting the demonstration, the commissioner and participating counties shall submit a report to the temporary president of the senate and the speaker of the assembly, not later than one year following the commencement of the program's operation, describing the experiences, feasibility and advisability of replication, and any additional recommendations for continuation, modification or cessation of the program.

§ 2559-a. Transportation. The municipality in which an eligible child resides shall, beginning with the first day of service, provide either directly, by contract, or through reimbursement at a mileage rate authorized by the municipality for the use of a private vehicle or for other reasonable transportation costs, for suitable transportation pursuant to section twenty-five hundred forty-five of this title. All

contracts for transportation of such children shall be provided pursuant to the procedures set forth in section two hundred thirty-six of the family court act, using the date on which the child's IFSP is implemented, in lieu of the date the court order was issued; provided, however, that the city of New York shall provide such transportation in accordance with the provisions of chapter one hundred thirty of the laws of nineteen hundred ninety-two, if applicable.

§ 2559-b. Regulations. The commissioner may adopt regulations necessary to carry out the provisions of this title. In promulgating such regulations, the commissioner shall incorporate coordinated standards and procedures, where applicable, and shall consider the regulations, guidelines and operating procedures of other state agencies that administer or supervise the administration of services to infants, toddlers and preschool children to ensure that families, service providers and municipalities are not unnecessarily required to meet differing eligibility, reporting or procedural requirements.

TITLE III CONTROL OF MIDWIFERY

TITLE IV INSTITUTIONS FOR CHILDREN

Section 2570. Children's institutions; regular physician required.

2571. Children's institutions; examination of children on admission.

2573. Children's institutions; inspections; reports.

2574. Children's institutions; environmental sanitation.

2575. Children's institutions; duty of local health officer.

§ 2570. Children's institutions; regular physician required. 1. Every institution in this state, operated for the express purpose of receiving or caring for dependent, neglected or destitute children or juvenile

delinquents, except hospitals, shall have attached thereto a regular physician of its selection duly licensed under the laws of the state and in good professional standing, whose name and address shall be kept posted conspicuously within such institution.

2. The words "juvenile delinquents" used in this article shall include all children whose commitment to an institution is authorized by law.

§ 2571. Children's institutions; examination of children on admission.

1. The administrative officer or person in charge of every institution in this state operated for the express purpose of receiving or caring for dependent, neglected or destitute children or juvenile delinquents, except hospitals, upon receiving a child therein, by commitment or otherwise, shall, before permitting such child to contact with other children, cause inquiry to be made concerning the presence or recent exposure of such child to a communicable disease.

2. If, on the basis of such inquiry, there is reason to suspect that such child may be ill or recently exposed to a communicable disease, such child shall not be permitted to contact other children until so authorized by the regular physician of the institution. A record of the results of all such inquiries and examinations shall be kept on file in the institution.

3. A thorough medical examination shall be performed on all children either immediately prior to admission to the institution or shortly thereafter.

§ 2573. Children's institutions; inspections; reports. 1. The administrative officer or person in charge and the regular physician of every institution caring for children referred to in this article shall make such reports concerning the physical condition and health of the children and the environmental sanitation of the institution as may be required by the state health commissioner, local health officer or health commissioner having jurisdiction.

2. In conjunction with the state department having general supervision, the commissioner may make inspection of such institutions from time to time with respect to the physical health and condition of the children and the environmental sanitation of the institution or he may direct that such inspections be made by the health officer having jurisdiction.

§ 2574. Children's institutions; environmental sanitation. Every institution caring for children referred to in this article shall comply with such orders, rules and regulations respecting water supply, milk supply, sewerage disposal, food handling, and other sanitary matters as are established by the state or local sanitary codes, rules or regulations or, in the case of milk supply, rules and regulations of the commissioner of agriculture and markets.

§ 2575. Children's institutions; duty of local health officer. 1. The county, part-county, city (over fifty thousand population) health commissioner or district state health officer within whose jurisdiction any institution for the care of children, referred to in this article, is situated, shall immediately investigate any complaint against the management of the institution as to the existence of any condition therein dangerous or detrimental to life or health.

2. If after such investigation, such health commissioner or health officer is satisfied that a condition exists therein which is dangerous or detrimental to life or health, he shall cause the said condition to be remedied without delay.

TITLE V

CHILDREN WITH PHYSICAL DISABILITIES

Section 2580. Children with physical disabilities; policy.

2581. Children with physical disabilities; definitions.

2582. Children with physical disabilities; duty of the

department.

2583. Children with physical disabilities; rules and regulations; limitations.

2584. Children with physical disabilities; transportation.

§ 2580. Children with physical disabilities; policy. It is the policy of the state of New York to provide medical service for the treatment and rehabilitation of children with physical disabilities.

§ 2581. Children with physical disabilities; definitions. As used in this article: 1. "Children with physical disabilities" means any persons under twenty-one years of age who are disabled by reason of a defect or disability, whether congenital or acquired by accident, injury, or disease, or who are suffering from long-term disease, including, but without limiting the generality of the foregoing, chronic granulomatous, cystic fibrosis, epidermolysis bullosa, muscular dystrophy, nephrosis, rheumatic fever and rheumatic heart disease, blood dyscrasies, cancer, lymphatic diseases, including, but not limited to: insufficiency of lymphatic circulatory function (to include all forms of lymphedema, both primary and secondary); lipedema; complex vascular diseases of the lymphatic vasculature, including lymphangiomatosis, lymphangioma-myomatosis, lymphangiectasias, lymphangiomas, cystic hygromas, Gorham's disease, lymphangiosarcoma, and complex vascular/lymphatic malformations and syndromes, brain injured, and chronic asthma, or from any disease or condition likely to result in a disability in the absence of treatment, provided, however, no child shall be deprived of a service under the provisions of this chapter solely because of the degree of developmental disability.

2. "Medical service" means such diagnostic, therapeutic, and rehabilitative care by medical and paramedical personnel, including hospital and related care, and drugs, prostheses, appliances, equipment and devices as necessary.

§ 2582. Children with physical disabilities; duty of the department.

1. The department shall on its own initiative provide, within the limits of the appropriations made therefor, such medical service for children with physical disabilities as in the judgment of the commissioner is needed.

2. The commissioner of health of any county or part-county health district or, in a county lacking a county or part-county health district, the medical director of the program for children with physical disabilities, or the department of health of the city of New York, may issue authorizations for medical service for children with physical disabilities, and the expenses thereof, when approved by such health commissioner, department of health or medical director and duly audited, shall be a charge upon the county, or upon the city of New York if such be the case, wherein the children are domiciled at the time application is made for such medical service.

3. Such health commissioner, department of health or county medical director may determine and order that the person or persons charged with the liability under the laws to support such child shall pay a part or all of such expenses. A parent or other person who is ordered to contribute to the cost of medical service authorized by this section may petition the family court , pursuant to section two hundred thirty-two of the family court act, for review of the order. Whenever a parent or other person who is ordered to contribute to the cost of medical service authorized by this section fails to make such contribution, the health commissioner, department of health or medical director may apply to the family court, pursuant to section two hundred thirty-two of the family court act, for an order compelling such contribution. The amount authorized to be paid for medical service shall be in full payment thereof and shall be accepted by the person or corporation furnishing such service in full payment thereof when any payment is made under such authorization by the county or by the city of New York, and no such person or corporation shall ask or receive directly or indirectly any other or additional compensation.

4. When the commissioner of health of any county or part-county health

district, or, in a county lacking a county or part-county health district, the medical director of the program for children with physical disabilities, or the department of health of the city of New York, shall issue authorizations for medical service for children with physical disabilities, the commissioner, if he approves such authorizations, shall certify to such effect, copies of which certification shall be filed with the clerk of the board of supervisors or other governing elective body of the county or chief fiscal officer of the city of New York and with the commissioner.

5. The medical service provided for in any authorization issued pursuant to subdivision two may be furnished and completed even though the person for whom such service is to be provided under such authorization shall have thereafter attained the age of twenty-one years; provided, however, that no such authorization shall provide for treatment beyond eighteen months from the date thereof.

6. The circumstance that a child is not eligible for medical assistance pursuant to the provisions of title eleven of article five of the social services law shall not be a bar to the furnishing and completion of the medical assistance for children with physical disabilities authorized by this title.

§ 2583. Children with physical disabilities; rules and regulations; limitations. 1. Such service shall be provided in accordance with rules and regulations established by the commissioner. The commissioner's rules and regulations may relate to:

(a) the defects, disabilities, diseases and conditions eligible under the program and the type and extent of care that may be offered.

(b) qualifications of professional personnel, both medical and paramedical.

(c) standards of institutional care, whether in general hospitals, special hospitals, long-term care facilities, or such other special facilities, whether inpatient or outpatient, as may be needed to obtain the services required.

(d) limitations on the amount of professional fees, and on rates in

general hospitals, special hospitals, long-term care facilities and special facilities for which reimbursement may be made under this article.

(e) standards and procedures for administration of programs for children with physical disabilities.

2. Sections two thousand five hundred eighty to two thousand five hundred eighty-three, inclusive, and section six hundred sixty, of this chapter, shall not apply to:

(a) children requiring permanent custodial care.

(b) children institutionalized in mental, correctional or penal institutions of the state of New York.

(c) children who, in the judgment of the commissioner, may not be expected to benefit from medical service.

(d) children whose parents or guardians object to medical services because of exclusive dependence for healing on the practice of religious tenets of any church.

§ 2584. Children with physical disabilities; transportation. 1. The department shall on its own initiative provide, within the limits of the appropriations made therefor, such transportation for such children with physical disabilities as in the judgment of the commissioner is needed to such places wherein the medical services outlined in section two thousand five hundred eighty-one of this chapter are administered or provided to such children.

2. When the commissioner of health of any county or part-county health district or the medical director of the program for children with physical disabilities, or the department of health of the city of New York, in pursuance of section two thousand five hundred eighty-two of this chapter, shall issue an authorization for medical service for any child with physical disabilities, including among the expenses thereof transportation necessary to obtain such services, the commissioner, if he approves such order, shall issue a certificate to such effect, copies of which shall be filed with the clerk of the board of supervisors or other governing elective body of the county or chief fiscal officer of

the city of New York and one in the office of the commissioner.

* TITLE VI

FEDERAL CHILD CARE AND ADULT FOOD PROGRAM

Section 2585. Federal child care and adult food program; establishment.

2586. Definitions.

2587. Program approval.

2588. Reimbursement.

2589. Rules and regulations.

* NB There are 2 Article VI's

§ 2585. Federal child care and adult food program; establishment.

There is hereby established within the department the federal child care and adult food program for the purpose of providing nutritious meals to children and adults in or under the auspices of institutions providing day care. The commissioner is authorized to develop and submit the plan required for participation in the federal child care and adult food program (42 USCS § 1766). The commissioner is authorized to take any action necessary or consistent with federal law, rule and regulation, to implement the provisions of this title.

§ 2586. Definitions. As used in this title, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Eligible institution" means any child or adult day care institution defined in federal law, rule or regulations eligible to receive cash assistance under the federal child care and adult food program. A child day care program shall be licensed by the department of social services or licensed or otherwise approved by a state or local government agency or shall operate under the auspices of a sponsoring organization licensed by the department of social services. An adult day care program shall be licensed and approved by the department or other state agency or shall operate under the auspices of a sponsoring

organization licensed or approved by the department or other state agency.

2. "Program" means the federal child care and adult food program. (42 USCS § 1766).

§ 2587. Program approval. 1. Eligible institutions seeking cash assistance under the program shall submit an application to the commissioner. Such application shall be in a format and quantity determined by the commissioner, and shall include:

- (a) a general description of the proposed program;
- (b) a copy of a valid license or other approval issued by the department, the department of social services or other state agency to provide or sponsor child or adult day care programs; and
- (c) such other information as required by the commissioner.

2. The commissioner shall not approve an eligible institution for receipt of cash assistance under this title unless the applicant:

- (a) accepts final administrative and financial responsibility for management of an effective food service;
- (b) possesses a valid license or other approval issued by the department, the department of social services or other state agency to operate or sponsor child or adult day care programs;
- (c) has not been seriously deficient in its operation of the program or any other program specified in federal law, rule or regulation;
- (d) demonstrates that it will provide adequate supervisory and operational personnel for overall monitoring and management of the program; and
- (e) meets standards prescribed in federal law, rule or regulation.

3. The commissioner shall provide written notice of approval or disapproval of the proposed application to the applicant.

§ 2588. Reimbursement. 1. The total amount of cash assistance provided pursuant to this title shall be limited to the amount of

federal funds appropriated for the program.

2. Eligible institutions approved by the commissioner pursuant to section two thousand five hundred eighty-seven of this title shall be reimbursed for meals, preparation of meals and administrative expenses when provided to children and adults in amounts specified under federal law, rule or regulation and consistent with the application as approved by the commissioner. In the event that eligible institutions request advance payment for meals, preparation of meals or administrative expenses in accordance with federal law, rule or regulation, such advance shall be paid if it is consistent with state and federal law, rule or regulation and the application as approved by the commissioner.

§ 2589. Rules and regulations. The commissioner may adopt and amend rules and regulations to effectuate the purposes and provisions of this title.

* TITLE VI

EMERGENCY NUTRITION AID PROGRAM FOR PREGNANT WOMEN AND ADOLESCENTS

Section 2590. Emergency nutrition aid program for pregnant women and adolescents; establishment.

2591. Eligibility.

2592. Rules and regulations.

* NB Expired March 31, 1986

* NB There are 2 Article VI's

*** § 2590. Emergency nutrition aid program for pregnant women and adolescents; establishment.** The emergency nutrition aid program for pregnant women and adolescents is established within the department of health.

* NB Expired March 31, 1986

*** § 2591. Eligibility.** Eligibility for the program shall be limited

to pregnant women and adolescents who, because of low income and dietary deficiencies, are at high risk endangering the nutritional well-being of their fetuses and risking the delivery of low birth weight infants.

* NB Expired March 31, 1986

* **§ 2592. Rules and regulations.** The commissioner of health may adopt rules and regulations to implement the emergency nutrition aid program.

* NB Expired March 31, 1986

TITLE VII YOUTH SPORTS

Section 2595. Football programs; information on concussions.

§ 2595. Football programs; information on concussions. 1. All tackle football programs in the state shall provide an informational packet about concussions and sub-concussive blows, and the injuries that might occur as a result of receiving such blows, to the parents or guardians of all children participating in such tackle football program. The informational packet shall be provided by the department and shall be available to be downloaded free of charge from the department's website.

2. For the purposes of this section, "tackle football program" shall include any practice, game or other activity which involves engaging in tackle football and which is organized by a school, adult, or public or private league or other entity whose purpose is to allow children to participate in contact football.

TITLE VIII CHILDHOOD OBESITY PREVENTION PROGRAM

Section 2599-a. Childhood obesity prevention program; establishment.

2599-b. Program development.

2599-c. School-based childhood obesity prevention and physical activity programs.

§ 2599-a. Childhood obesity prevention program; establishment. The childhood obesity prevention program is established within the department.

§ 2599-b. Program development. 1. The program shall be designed to prevent and reduce the incidence and prevalence of obesity in children and adolescents, especially among populations with high rates of obesity and obesity-related health complications including, but not limited to, diabetes, heart disease, cancer, osteoarthritis, asthma, emphysema, chronic bronchitis, other chronic respiratory diseases and other conditions. The program shall use recommendations and goals of the United States departments of agriculture and health and human services, the surgeon general and centers for disease control and prevention in developing and implementing guidelines for nutrition education and physical activity projects as part of obesity prevention efforts. The content and implementation of the program shall stress the benefits of choosing a balanced, healthful diet from the many options available to consumers, without specifically targeting the elimination of any particular food group, food product or food-related industry.

2. The childhood obesity prevention program shall include, but not be limited to:

(a) developing media health promotion campaigns targeted to children and adolescents and their parents and caregivers that emphasize increasing consumption of low-calorie, high-nutrient foods, decreasing consumption of high-calorie, low-nutrient foods and increasing physical activity designed to prevent or reduce obesity;

(b) establishing school-based childhood obesity prevention nutrition education and physical activity programs including programs described in section twenty-five hundred ninety-nine-c of this article, as well as other programs with linkages to physical and health education courses, and which utilize the school health index of the National Center for Chronic Disease Prevention and Health Promotion or other recognized

school health assessments pursuant, but not limited, to article nineteen of the education law;

(c) establishing community-based childhood obesity prevention nutrition education and physical activity programs including programs which involve parents and caregivers, and which encourage communities, families, child care and other settings to provide safe and adequate space and time for physical activity and encourage a healthy diet, and can be in coordination with county cooperative extension programs established pursuant to section two hundred twenty-four-b of the county law;

(d) coordinating with the state education department, department of agriculture and markets, office of parks, recreation and historic preservation, office of temporary and disability assistance, office of children and family services and other federal, state and local agencies to incorporate strategies to prevent and reduce childhood obesity into government food assistance, health, education and recreation programs;

(e) sponsoring periodic conferences or meetings to bring together experts in nutrition, exercise, public health, mental health, education, parenting, media, food marketing, food security, agriculture, community planning and other disciplines to examine societal-based solutions to the problem of childhood obesity and issue guidelines and recommendations for New York state policy and programs;

(f) developing training programs for medical and other health professionals to teach practical skills in nutrition and exercise education to children and their parents and caregivers;

(g) developing screening programs in coordination with health care providers and institutions including but not limited to day care centers and schools for overweight and obesity for children aged two through eighteen years, using body mass index (BMI) appropriate for age and gender, and notification, in a manner protecting the confidentiality of such children and their families, of parents of BMI status, and explanation of the consequences of such status, including recommended actions parents may need to take and information about resources and referrals available to families to enhance nutrition and physical activity to reduce and prevent obesity; and

(h) coordinating with the education department, office of temporary and disability assistance, office of children and family services and

other federal, state and local agencies to incorporate strategies to curtail the incidence of asthma, chronic bronchitis and other chronic respiratory diseases to enable adults and children to safely increase physical activity.

3. The department, in cooperation with the education department, shall periodically collect and analyze information from schools, health and nutrition programs and other sources to determine the prevalence of childhood obesity in New York state, and to evaluate, to the extent possible, the effectiveness of the childhood obesity prevention program.

§ 2599-c. School-based childhood obesity prevention and physical activity programs. The commissioner, in cooperation with the commissioners of education and agriculture and markets, and county boards of cooperative extension, shall encourage the establishment of school-based childhood obesity prevention and physical activity programs that promote:

1. A healthy school environment, including physical and aesthetic surroundings and culture designed to prevent and reduce the incidence and prevalence of obesity; and

2. Parent/community involvement, including an integrated school, parent, and community approach for enhancing the health and well-being of students.

§ 2599-d. Powers of commissioner. The commissioner may administer directly or through contract, within the amount of funds allocated and within amounts appropriated pursuant to paragraph (k) of subdivision one of section twenty-eight hundred seven-v of this chapter, the childhood obesity prevention program. The commissioner shall also make grants, within the amount of funds available therefor, for community-based and school-based projects targeted to high-risk populations and communities to implement the provisions of this title.

ARTICLE 25-A
REPRODUCTIVE HEALTH ACT

Section 2599-aa. Policy and purpose.
2599-bb. Abortion.
2599-bb-1. Reproductive freedom and equity grant program.

§ 2599-aa. Policy and purpose. The legislature finds that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality. Therefore, it is the policy of the state that:

1. Every individual has the fundamental right to choose or refuse contraception or sterilization.
2. Every individual who becomes pregnant has the fundamental right to choose to carry the pregnancy to term, to give birth to a child, or to have an abortion, pursuant to this article.
3. The state shall not discriminate against, deny, or interfere with the exercise of the rights set forth in this section in the regulation or provision of benefits, facilities, services or information.

§ 2599-bb. Abortion. 1. A health care practitioner licensed, certified, or authorized under title eight of the education law, acting within his or her lawful scope of practice, may perform an abortion when, according to the practitioner's reasonable and good faith professional judgment based on the facts of the patient's case: the patient is within twenty-four weeks from the commencement of pregnancy, or there is an absence of fetal viability, or the abortion is necessary to protect the patient's life or health.

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

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

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

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

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

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

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

(a) Increase access to care by growing the capacity of abortion providers to meet present and future care needs. Funds may be awarded to support the recruitment, hiring, and retention of clinical and medical staff, costs of increasing the number of hours, days, and/or alternate times for currently employed clinical staff to provide increased access, care management and navigation, staff training, outreach and marketing costs, and other operational needs that increase access to abortion care.

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

rendering provider.

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

5. The department and any non-profit organization or abortion provider receiving funds from the program shall take all necessary steps to ensure the confidentiality of the individuals receiving services pursuant to state and federal laws. The commissioner may request aggregate, de-identified information about how funding allocated pursuant to the program is spent, provided that no information which, alone or in combination, would permit a patient, provider, or an individual who sought, received, provided, or supported health care services under the program to be identified may be requested or shared.

ARTICLE 25-B

GESTATIONAL SURROGACY

Section 2599-cc. Gestational surrogacy.

§ 2599-cc. Gestational surrogacy. 1. The commissioner shall promulgate regulations on the practice of gestational surrogacy. Such regulations shall include, but not be limited to:

(a) guidelines and procedures for obtaining fully informed consent from potential persons acting as surrogates, including but not limited to a full disclosure of any known or potential health risks and mental health impacts associated with acting as a surrogate;

(b) the development and distribution, in printed form and on the department's website, of informational material relating to gestational surrogacy;

(c) the establishment of a voluntary central tracking registry of

persons acting as surrogates, as reported by surrogacy programs licensed by the department pursuant to article forty-four of the general business law upon the affirmative consent of a person acting as surrogate. Such registry shall provide a means for gathering and maintaining accurate information on the:

- (i) number of times a person has acted as a surrogate;
- (ii) health information of the person acting as surrogate; and
- (iii) other information deemed appropriate by the commissioner;
- (d) the development of guidelines, procedures or protocols, in consultation with the American college of obstetricians and gynecologists and the American society for reproductive medicine, to assist physicians in screening potential surrogates for their ability to serve as a surrogate as required under subdivision four of section 581-402 of the family court act including taking into consideration the potential surrogates family medical history and complications from prior pregnancies and known health conditions that may pose a risk to the potential surrogate during pregnancy; and
- (e) the development of guidance to reduce conflicts of interest among physicians providing health care services to the surrogate.

2. All such regulations shall maintain the anonymity of the person acting as surrogate and any resulting offspring and govern access to information maintained by the registry. Such registry shall comply with all state and federal laws and regulations related to maintaining the privacy and confidentiality of records contained with the registry.

ARTICLE 26

HELEN HAYES HOSPITAL

Section 2600. Helen Hayes Hospital; hospital care and treatment.

2601. Helen Hayes Hospital; functions; powers and duties.

2602. Helen Hayes Hospital; charges for service and reimbursement.

§ 2600. Helen Hayes Hospital; hospital care and treatment. 1. The Helen Hayes Hospital is continued for the care and treatment of persons

who are physically disabled, deformed or are suffering from disease from which they are likely to become physically disabled or deformed.

2. The patients in such hospital shall be permitted to exercise and enjoy religious profession and worship freely and without discrimination or preference.

§ 2601. Helen Hayes Hospital; functions; powers and duties. 1. The Helen Hayes Hospital may receive persons who are physically disabled, deformed or suffering from disease from which they are likely to become physically disabled or deformed, for care, study and experimental or other treatment, under regulations established by the commissioner.

2. No person provided for by this article, however, shall be admitted to the hospital unless at the time of his admission he is capable of benefiting from care in terms of improved capacity for remunerative occupation or self-sufficiency.

3. The hospital shall, in conjunction with its provision of care and treatment, conduct investigations of the cause, mortality, treatment, prevention and cure of physically disabling or deforming diseases and conditions.

§ 2602. Helen Hayes Hospital; charges for service and reimbursement. 1. The commissioner shall establish the rates to be paid for the maintenance, care and treatment of all patients admitted to the Helen Hayes Hospital.

2. The commissioner shall require that the director of the hospital shall render bills at suitable intervals and a final bill as soon as practicable on discharge of a patient, to the person or agency in each instance who guarantees payment or, if payment is to be made from public funds, to the proper fiscal officer of the agency or county or municipality indicated.

3. The commissioner may in his discretion, in proper cases, where substantial justice will best be served thereby, waive such bills or compromise any portion of such bills for the maintenance, care and treatment received or furnished to patients in the hospital. Such waiver or compromise shall be made only upon prior approval of the comptroller and the attorney general when they deem it to be for the best interest of the state.

ARTICLE 26-A

NEW YORK STATE VETERANS' HOME

Section 2630. Purpose.

2631. Board of visitors; special provision.

2632. Admission to home.

2633. Acquisition and application of property.

2634. Designation of the "New York State Women Veterans Memorial Community Room".

2635. Designation of the "Arnold Swanson Community Room".

§ 2630. Purpose. The New York state home for veterans and their dependents at Oxford, the New York state home for veterans in the city of New York, the New York state home for veterans in western New York and the New York home for veterans in the lower-Hudson Valley shall be for the care of aged dependent veterans and their spouses, veterans' mothers and fathers, unremarried surviving spouses, and army nurses.

§ 2631. Board of visitors; special provision. The board of visitors of each such home shall consist of nine members appointed from the members of the New York departments of the major organizations of war veterans to which charters have been issued by Acts of Congress or of their women's auxiliaries. The terms of office of such visitors hereafter appointed shall be five years, and they shall be so appointed that the terms of two of the members shall expire on the first day of February of each year, except that the term of but one member shall so expire every fifth year. Appointments shall be so made that there will

be at all times four women and five men members of such board.

§ 2632. Admission to home. 1. Every veteran of the armed forces of the United States, who (i) (A) was separated or discharged under honorable conditions after serving on active duty therein for a period of not less than thirty days, or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable after serving on active duty therein for a period of not less than thirty days, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable after serving on active duty therein for a period of not less than thirty days, or (ii) (A) was separated or discharged under honorable conditions after serving on active duty therein for a period of not less than thirty days or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable after serving on active duty therein for a period of not less than thirty days, and who was a recipient of the armed forces expeditionary medal, navy expeditionary medal or marine corps expeditionary medal for participation in operations in Lebanon from June first, nineteen hundred eighty-three to December first, nineteen hundred eighty-seven, in Grenada from October twenty-third, nineteen hundred eighty-three to November twenty-first, nineteen hundred eighty-three, or in Panama from December twentieth, nineteen hundred eighty-nine to January thirty-first, nineteen hundred ninety, or in Bosnia and Herzegovina from November twenty-first, nineteen hundred ninety-five to November first, two thousand seven, or was a recipient of the Kosovo campaign medal or (iii) (A) was separated or discharged under honorable conditions after serving on active duty therein for a period of not less than thirty days or (B) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable after serving on active duty

therein for a period of not less than thirty days, or (C) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable after serving on active duty therein for a period of not less than thirty days, and who served during the period of actual hostilities of either

(a) the Spanish-American war; or

(b) the incidental insurrection in the Philippines prior to July fourth, nineteen hundred two; or

(c) world war I between April sixth, nineteen hundred seventeen and November eleventh, nineteen hundred eighteen, both inclusive; or

(d) world war II between December seventh, nineteen hundred forty-one and December thirty-first, nineteen hundred forty-six, both inclusive, or who was employed by the War Shipping Administration or Office of Defense Transportation or their agents as a merchant seaman documented by the United States Coast Guard or Department of Commerce, or as a civil servant employed by the United States Army Transport Service (later redesignated as the United States Army Transportation Corps, Water Division) or the Naval Transportation Service; and who served satisfactorily as a crew member during the period of armed conflict, December seventh, nineteen hundred forty-one, to August fifteenth, nineteen hundred forty-five, aboard merchant vessels in oceangoing, i.e., foreign, intercoastal, or coastwise service as such terms are defined under federal law (46 USCA 10301 & 10501) and further to include "near foreign" voyages between the United States and Canada, Mexico, or the West Indies via ocean routes, or public vessels in oceangoing service or foreign waters and who has received a Certificate of Release or Discharge from Active Duty and a discharge certificate, or an Honorable Service Certificate/Report of Casualty, from the Department of Defense, or who served as a United States civilian employed by the American Field Service and served overseas under United States Armies and United States Army Groups in world war II during the period of armed conflict, December seventh, nineteen hundred forty-one through May eighth, nineteen hundred forty-five, and who (i) was discharged or released therefrom under honorable conditions, or (ii) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from

such service, or (iii) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or who served as a United States civilian Flight Crew and Aviation Ground Support Employee of Pan American World Airways or one of its subsidiaries or its affiliates and served overseas as a result of Pan American's contract with Air Transport Command or Naval Air Transport Service during the period of armed conflict, December fourteenth, nineteen hundred forty-one through August fourteenth, nineteen hundred forty-five, and who (iv) was discharged or released therefrom under honorable conditions, or (v) has a qualifying condition, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service, or (vi) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and has received a discharge other than bad conduct or dishonorable from such service; or

(e) Korean conflict between June twenty-seventh, nineteen hundred fifty and January thirty-first, nineteen hundred fifty-five, both inclusive; or

(f) Viet Nam conflict between November first, nineteen hundred fifty-five and May seventh, nineteen hundred seventy-five, both inclusive; or

(g) veterans who served in the United States military and were exposed to radiation during military service in a "radiation-risk activity" defined as participation in the occupation of Hiroshima or Nagasaki, Japan between August sixth, nineteen hundred forty-five through July first, nineteen hundred forty-six; were prisoners of war in Japan during World War II; onsite participation in a test involving the atmospheric detonation of a nuclear device, whether or not the testing nation was the United States; or

(h) in the Persian Gulf conflict from the second day of August, nineteen hundred ninety to the end of such conflict including military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal or the Afghanistan campaign medal; and who was a resident of the state of New York at the time of entry upon such active duty or who

shall have been a resident of this state for six months next preceding the application for admission shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department. Any such veteran or dependent, who otherwise fulfills the requirements set forth in this section, may be admitted directly to the skilled nursing facility or the health related facility provided such veteran or dependent is certified by a physician designated or approved by the department to require the type of care provided by such facilities.

2. The unremarried surviving spouse as such term is defined under section 101 of title thirty-eight of the United States Code of any such veteran, or the unremarried surviving spouse, mother or father of any such member of the armed forces of the United States who died while on active duty, notwithstanding the length of such service, shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department and by the secretary of the United States department of veterans affairs.

3. The spouse, as such term is defined under section 101 of title thirty-eight of the United States Code, of any such veteran, unless such veteran and his or her spouse have been legally separated, shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department and by the secretary of the United States department of veterans affairs.

4. No spouse or unremarried surviving spouse of such a veteran shall be admitted as a resident of said home unless married to such veteran at least one year prior to the date of application.

5. Preference in admission shall be given as follows: first, to

veterans accompanied by their spouses based upon severity of illness or disability and need for care; second, to other eligible veterans pursuant to clause (ii) or (iii) of subdivision one of this section based upon severity of illness or disability and need for care and the order of the date of the conflict or operation listed in such clauses; third, to other eligible veterans pursuant to clause (i) of subdivision one of this section based upon severity of illness or disability and need for care; fourth, to spouses and unremarried surviving spouses based upon severity of illness or disability and need for care; fifth, to mothers and fathers based upon severity of illness or disability and need for care.

6. The board of visitors shall require an applicant for admission to such home to file an affidavit of New York state residence and the affidavits of at least two householders in and residents of the county in New York state of which the applicant claims at the time of such application to be a resident; and such affidavits shall, on presentation, be accepted and received as sufficient proof, unless contradicted, of the residence of such applicant in any actions or proceedings against such county in which such residence of such applicant is material.

7. The regulations of the department shall require that each applicant for admission shall furnish a certification of all property of which he or she is possessed and of all sources of income and that, following admission, each resident shall be required to furnish further certifications as to such facts from time to time, but not oftener than at intervals of twelve months, and shall also require the payments by residents of the home from such resources or income, or both, such amounts in payment on account of the care and maintenance provided by the home as the department shall find to be reasonable.

§ 2633. Acquisition and application of property. Subject to the regulations of the department, the board of visitors or the duly appointed treasurer of the homes, as agent of the department, may receive, retain and expend receipts other than state appropriations, any

money or other personal property given, bequeathed or entrusted to the board of visitors or duly appointed treasurer, for the purposes for which it is given or bequeathed to the homes or entrusted for safekeeping or, if unaccompanied by conditions or limitations, for any of the purposes of the homes or for the convenience of the residents thereof.

§ 2634. Designation of the "New York State Women Veterans Memorial Community Room". The communal area multi-purpose room of the New York state home for veterans in the city of New York, such room as referred to as area one hundred ninety-four in the architectural plans and drawings of such home for veterans, shall be designated and known as the "New York State Women Veterans Memorial Community Room" in honor of all women veterans of this state.

§ 2635. Designation of the "Arnold Swanson Community Room". The communal area multi-purpose room of the New York state home for veterans in the city of Batavia shall be designated and known as the "Arnold Swanson Community Room" in honor of Arnold Swanson.

ARTICLE 27

BUREAU OF CHRONIC DISEASE AND GERIATRICS

Section 2700. Bureau of chronic disease and geriatrics established.

2701. Purpose and functions.

2702. Powers and duties.

§ 2700. Bureau of chronic disease and geriatrics established. The state department of health shall establish a bureau of chronic disease and geriatrics, which shall develop a program designed to improve and protect the health and vitality of middle-aged and elderly citizens of the state.

§ 2701. Purpose and functions. The department, at the discretion of the commissioner, shall:

1. Plan public health programs to aid in the prevention, rehabilitation and control of degenerative diseases and chronic illnesses.

2. Develop a program for integrating community and institutional agencies and facilities and for utilization of geriatric techniques to provide a comprehensive program of prevention, rehabilitation and control of degenerative diseases and chronic illnesses.

3. Develop a plan for periodic health inventories for the middle-aged and elderly.

4. Explore possibilities of reducing cost and improving care of the chronically ill through use of non-institutional as well as institutional facilities.

5. Develop laboratory, clinical and statistical research on chronic disease and health problems of older people in consultation with the state medical society and other agencies, including the state department of mental hygiene and the state university of New York.

6. (a) Carry on programs of professional education and training of medical students, physicians and nurses in the prevention, rehabilitation, medical and nursing care of diseases of older people.

(b) Plan and carry out the Alzheimer's disease assistance program to enhance support services for people with Alzheimer's disease and their caregivers. Services to be provided by the program may include:

(i) education and training for health care practitioners, caregivers, volunteers and informal caregivers regarding services for or the treatment of persons with Alzheimer's disease;

(ii) counseling for families of persons with Alzheimer's disease;

(iii) respite services for informal caregivers of persons with Alzheimer's disease; and

(iv) technological assistance for persons with Alzheimer's disease.

The commissioner shall make grants under this paragraph within amounts appropriated therefore to public and not-for-profit entities including local health agencies, health care providers, higher educational institutions affiliated with medical facilities, community-based organizations and other organizations with demonstrated expertise in serving persons with Alzheimer's disease. The commissioner may coordinate grants under this paragraph with the availability of grants from other sources. The commissioner may also accept or seek grants from other sources to enhance amounts appropriated to this program.

7. Plan and carry out programs to stimulate the prevention, rehabilitation and control of chronic illnesses and the promotion of the health of adult, middle-aged and older persons, through "day hospital" and a "meals on wheels" demonstration projects.

§ 2702. Powers and duties. The commissioner shall have the power and it shall be his duty to employ such assistants and personnel, within the amount of the appropriation, as is necessary to carry out the provisions of this article.

ARTICLE 27-A

OSTEOPOROSIS PREVENTION AND EDUCATION

Section 2705. Legislative findings and declarations.

2706. Osteoporosis prevention and education program established.

§ 2705. Legislative findings and declarations. The legislature hereby finds and declares that osteoporosis is a public health problem that poses a threat to the health and quality of life to as many as twenty-four million Americans; and that it may ultimately affect as many as half of all women in the United States over the age of forty-five and an increasing number of men; and costs the nation ten billion dollars a year in hospitalization and treatment for resulting injuries, including chronic disability, pain, and the need for long term care.

The legislature further finds and declares that over one million fractures a year result from osteoporosis and that the pain, discomfort, immobility and social isolation that may result from fractures affect quality of life, threaten people's ability to live independently and costs millions annually in nursing home and assistive care.

The legislature further finds and declares that a plan should be established to insure the availability of comprehensive educational services in communities, and that such services include awareness of the disease, its rate of incidence, risk factors, facts about its progression, and implications during pregnancy, the peri-menopausal and post-menopausal years, and in later life; education about the prevention of osteoporosis including nutrition, positive health habits and exercise, and their benefits from an early age; education regarding the availability and significance of diagnostic screening as well as predisposing factors including genetic disposition and interventions for those who already have bone mass loss or those who may be at high risk of bone mass loss; education about available and experimental treatments and the benefits, risks, and side effects of each.

The legislature hereby finds and declares that educating the public about this potentially devastating disease is of paramount importance and that educating the public throughout the state is in every respect in the public interest and to the benefit of all persons in this state.

§ 2706. Osteoporosis prevention and education program established. 1. There is hereby created within the department the osteoporosis prevention and education program. This program is established to promote public awareness of the causes of osteoporosis, options for prevention, the value of early detection and possible treatments, including their benefits and risks.

2. The program shall include: (a) establishment of a public education and outreach campaign to promote osteoporosis prevention and education that will enable individuals to make informed choices about their

health, including, but not limited to the following:

- (1) cause and nature of the disease;
- (2) risk factors;
- (3) impact of menopause;
- (4) impact of drug interactions;
- (5) prevention, including but not limited to:
 - (i) nutrition and diet and,
 - (ii) physical exercise;
- (6) diagnostic procedures and appropriate indications for their use;
- (7) all available treatment options, including benefits and risks;
- (8) environmental safety and injury prevention;
- (9) implications of hip fracture and the potential options for rehabilitation;
- (10) rest and use of appropriate body mechanics;
- (11) availability of osteoporosis diagnostic and treatment services in the community.

(b) development of educational materials to be made available for consumers, particularly targeted to high risk groups, through local departments of health, local health care practitioners, practitioners of gerontology and geriatrics, other health care providers, including, but not limited to, health maintenance organizations, hospitals, walk-in medical care centers, mobile care units, surgi-centers, health-oriented places of business, clinics and organizations serving women and the aged populations.

(c) development and provision of professional education programs for health care providers and health-related community-based organizations, including, but not limited to, the following:

- (1) research findings;
- (2) cause and nature of the disease;
- (3) risk factors, including but not limited to, lifestyle, heredity, and drug interactions;
- (4) impact of menopause;
- (5) prevention, including, but not limited to:
 - (i) nutrition and diet and,
 - (ii) physical exercise;
- (6) diagnostic procedures and appropriate indications for their use;
- (7) all medical and surgical treatment options, including experimental

and established drug therapies, and the benefits and risks of each option;

(8) environmental safety and injury prevention;

(9) availability of osteoporosis diagnostic and treatment and support services in the community.

3. The commissioner shall seek any federal waiver or waivers that may be necessary to maximize funds from the federal government, including, but not limited to, funds provided under Titles XVIII and XIX of the federal Social Security Act for the services provided under this section. The commissioner may accept any grants, awards or other funds or appropriations as may be made available for the purposes of this section.

ARTICLE 27-AA

NEW YORK STATE KIDNEY DISEASE INSTITUTE

Section 2710. Legislative findings and purpose.

2711. New York state kidney disease institute; organization.

2712. Functions, powers and duties.

§ 2710. Legislative findings and purposes. It is hereby declared and found that one of the major problems facing medicine and the public health and welfare is the lack of trained individuals, available facilities, research and equipment for the discovery, evaluation, diagnosis, treatment and cure of kidney disease. It is estimated that more than two thousand people die in New York state each year from kidney failure. No parallel situation in medicine exists today where techniques have been developed for the diagnosis and prevention of disease which would save lives, yet at the same time people continue to progress to chronic kidney disease and death only for the lack of facilities for diagnosis and treatment. New York state must take the initiative to combat this indiscriminate and often needless killer. Basic research is needed into the nature of diseases of the kidneys and the problems of kidney transplantation; in developing mass testing procedures for the early detection of kidney disease; and for the

development of more effective and economical devices for blood purification. An intensive survey of state-wide needs and facilities is necessary to formulate a long-range program for the state.

It is imperative that a comprehensive program to combat kidney disease be implemented through the combined and correlated efforts of state and local governments, medicine, universities, non-profit organizations and individuals. The program provided by this article is designed to bring to bear all the possible resources of the state and to coordinate the efforts of the state in this vital matter of public health.

§ 2711. New York state kidney disease institute; organization. 1. The New York state kidney disease institute is hereby created within the department of health.

2. The commissioner shall appoint a director of the institute and may employ such assistants and personnel, within the amounts appropriated, as is necessary to carry out the provisions of this article.

§ 2712. Functions, powers and duties. 1. In order to further the declared purposes of this article, the institute shall have the following functions, powers and duties:

(a) To conduct a survey of all of the existing facilities within the state having to do with the diagnosis, evaluation and treatment of patients with kidney disease and to prepare and submit its findings and a specific program of action.

(b) To evaluate the need for the creation of local or regional facilities and for the establishing of a major kidney research center.

(c) To develop and administer scientific investigations into the cause, prevention, methods of treatment and cure of renal disease, including research into transplantation of kidneys.

(d) To develop techniques for an effective method of mass testing for the detection of kidney diseases and urinary tract infections.

(e) To develop more efficient methods of medical care for kidney disease and to develop more effective and economical kidney dialysis

equipment.

(f) To survey and evaluate the need for a program of professional education and training for medical students, physicians and nurses in the care and treatment of kidney diseases.

(h) To enter into such contracts and agreements with individuals, colleges, universities, associations, corporations, municipalities and other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of this article. Such contracts may provide for payment by the state, within the limit of funds available, for materials, equipment or services.

2. The commissioner may adopt rules and regulations necessary to effectuate the purposes and provisions of this article.

ARTICLE 27-B

TREATMENT OF HYPERTENSION

TITLE I. Mary Lasker Heart and Hypertension Institute (§§ 2720-2722).

II. Centers for the treatment of hypertension (§§ 2723-2724).

TITLE I

MARY LASKER HEART AND HYPERTENSION INSTITUTE

Section 2720. Legislative declaration.

2721. Mary Lasker Heart and Hypertension Institute;
organization.

2722. Commissioner; functions, powers and duties.

§ 2720. Legislative declaration. The rising incidence of heart disease, strokes and hypertension over the past twenty years has caused increasing awareness and concern among public health officials and private practitioners. It is imperative that new concepts be developed to combat the problems of heart disease, stroke and hypertension by attempting to reduce the causes leading to these diseases. The program provided by this article is designed to prevent heart disease, stroke and hypertension by concentrating on the elimination of risk factors

associated therewith. In order to provide for the protection and promotion of the health of the inhabitants of the state, the department of health shall have the central and comprehensive responsibility for the development and administration of the state's policy with respect to the conduct of scientific investigation and research concerning the causes, prevention, treatment and care of hypertension.

§ 2721. Mary Lasker Heart and Hypertension Institute; organization.

The commissioner shall establish within the department a heart and hypertension institute to be named the Mary Lasker Heart and Hypertension Institute for the purpose of promoting the screening, evaluation and methods of treatment of hypertension.

§ 2722. Commissioner; functions, powers and duties. In order to further the declared purposes of this article, the commissioner shall have the following functions, powers and duties:

1. to conduct scientific investigations into the causes, prevention, evaluation and treatment of hypertension;
2. to develop more efficient methods for screening, evaluation and treatment of hypertension;
3. promote programs of professional education and training in the prevention of heart disease and hypertension and the rehabilitation of victims of heart disease and hypertension for physicians, medical students, nurses, pharmacists and persons in the public health profession;
4. gather data and statistics relative to the prevention of heart disease and hypertension and develop methods and procedures for the rehabilitation of these victims;
5. enter into such contracts and agreements with individuals, colleges, universities, associations, corporations, municipalities and

other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of this article.

TITLE II

CENTERS FOR THE TREATMENT OF HYPERTENSION

Section 2723. Centers for treatment of hypertension; establishment by commissioner.

2724. Commissioner; additional functions, powers and duties.

§ 2723. Centers for treatment of hypertension; establishment by commissioner. Pursuant to rules and regulations of the department, the commissioner shall establish such centers throughout the state as he deems necessary to provide a program of treatment and care for hypertension and promote the diagnosis, screening, evaluation and methods of treatment of hypertension. The commissioner shall also designate the geographic areas to be served by such center and may provide for the proper administration of such centers.

§ 2724. Commissioner; additional functions, powers and duties. In order to further the declared purposes of this title, the commissioner shall have the following functions, powers and duties:

1. to develop programs for screening, evaluation and treatment of hypertension;

2. to enter into contracts and agreements to provide for the screening, evaluation and treatment of hypertension pursuant to this section by July first, nineteen hundred eighty-two;

3. to require as the commissioner may determine to be appropriate that any facility established, incorporated, licensed or regulated pursuant to the provisions of article twenty-eight or forty-seven of this chapter, test for hypertension as part of their ordinary and regular care or treatment of patients and as necessary screen, treat and

diagnose the incidence of hypertension;

4. to apply for special grants from the federal government and any institution making grants for such purposes and use any monies so obtained to supplement any other monies made available from any source for the purposes of this title;

5. to require persons receiving treatment for hypertension in any center providing such treatment to pay a fee established by the commissioner on a sliding fee scale based on the treatment recipient's ability to pay after applying against the total cost of such treatment the amounts received from third party payors.

ARTICLE 27-C

BIRTH DEFECTS INSTITUTE

Section 2730. Declaration of policy.

2731. Birth defects institute.

2732. Commissioner; functions, powers and duties.

2733. Reporting of birth defects; confidentiality of information.

§ 2730. Declaration of policy. Occurrence of malformation or inherited disease at the time of birth is a tragedy for the child, the family and the community, and a matter of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, the department of health shall have the central and comprehensive responsibility for the development and administration of the state's policy with respect to the conduct of scientific investigations and research concerning the causes, prevention, treatment and cure of birth defects and genetic and allied diseases.

§ 2731. Birth defects institute. The commissioner shall establish within the department a birth defects institute for the purposes of

initiating and conducting investigations of the causes, mortality, methods of treatment, prevention and cure of birth defects and genetic and allied diseases.

§ 2732. Commissioner; functions, powers and duties. The commissioner shall have the following powers and duties:

(a) To conduct scientific investigations and surveys of the causes, mortality, methods of treatment, prevention and cure of birth defects and genetic and allied diseases.

(b) To publish from time to time the results of such investigations and surveys for the benefit of the public health and from time to time collate such publications for distribution to scientific organizations and qualified scientists and physicians.

(c) To carry on programs of professional education and training of medical students, physicians, nurses, scientists and technicians in the causes, methods of treatment, prevention and cure of birth defects and genetic and allied diseases.

(d) To conduct and support counseling services.

§ 2733. Reporting of birth defects; confidentiality of information.

1. Birth defects and genetic and allied diseases shall be reported by physicians, hospitals, and persons in attendance at births in the manner and on such forms as may be prescribed by the commissioner.

2. Such reports and information shall be kept confidential and shall not be admissible as evidence in an action or proceeding in any court or before any other tribunal, board, agency or person. The commissioner may, however, publish analyses of such reports and information from time to time for scientific and public health purposes, in such a manner as to assure that the identities of the individuals concerned cannot be ascertained.

ARTICLE 27-CC

NEW YORK STATE TRAUMATIC BRAIN INJURY PROGRAM

Section 2740. Traumatic brain injury program.

2741. Definitions.

2742. Functions, powers and duties of the department.

2743. Funding of traumatic brain injury services.

2744. The traumatic brain injury services coordinating council.

§ 2740. Traumatic brain injury program. The department shall have the central responsibility for administering the provisions of this article and otherwise coordinating the state's policies with respect to traumatic brain injury, in consultation with the office for people with developmental disabilities, the office of mental health, the department of education, the office of alcoholism and substance abuse services, the department of social services, the office of the advocate for the disabled and the commission on quality of care for the mentally disabled.

§ 2741. Definitions. As used in this article:

1. "Traumatic brain injury" means an acquired injury to the brain caused by an external physical force resulting in total or partial disability or impairment and shall include but not be limited to damage to the central nervous system from anoxic/hypoxic episodes or damage to the central nervous system from allergic conditions, toxic substances and other acute medical/clinical incidents. Such term shall include, but not be limited to, open and closed brain injuries that may result in mild, moderate or severe impairments in one or more areas, including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-solving, sensory perceptual and motor abilities, psycho-social behavior, physical functions, information processing and speech. Such term shall not include progressive dementias and other mentally impairing conditions, depression and psychiatric disorders in which there is no known or obvious central nervous system damage, neurological, metabolic and other medical conditions of chronic, congenital or degenerative nature or brain injuries induced by birth trauma.

2. "Concussion" means a mild traumatic injury to the brain that is characterized by immediate and transient alteration of mental status and level of consciousness, resulting from mechanical force or trauma.

§ 2742. Functions, powers and duties of the department. The department shall have the following powers and duties:

1. to develop a comprehensive statewide program that includes medical, housing, vocational, educational, transportation, social, personal care, family support, day program services, community re-entry services, outpatient rehabilitation services and other essential services;

2. to develop outreach services to provide coordinated information regarding assistance available to persons with traumatic brain injury and their families;

3. to develop and maintain a clearinghouse of information on traumatic brain injuries and concussions, including but not limited to, resources that support the development and implementation of community-based services and rehabilitation;

4. to track the amount of and cost of services provided to persons with traumatic brain injury placed in out-of-state treatment settings;

5. to develop innovative educational programs on the causes and prevention of traumatic brain injuries and concussions, with an emphasis on outreach campaigns. Such programs and information shall include, but not be limited to, treatment and services for persons with traumatic brain injury and/or a concussion and their families;

6. to accept and expend any grants, awards of other funds or appropriations as may be available for these purposes, subject to limitations as to the approval of expenditures and audits as prescribed for state funds by the state finance law;

7. to gather and disseminate statistics and conduct investigations and research relating to the causes and prevention of traumatic brain injuries and concussions and the treatment of such injuries, including the methods and procedures for rehabilitation, including from time to time, such publications for distribution to appropriate scientific organizations;

8. to contract with independent consultants to conduct assessments of the needs of persons with traumatic brain injury;

9. to develop training programs for persons providing discharge plans and case management; and

10. to develop standards for licensing or certifying residential and non-residential services for persons with traumatic brain injury to the extent that such services are not otherwise subject to the jurisdiction of another state agency.

§ 2743. Funding of traumatic brain injury services. 1. The department shall develop a biennial plan and priorities for the funding of services and programs as authorized by this article, with emphasis on the development and expansion of community-based services and programs.

2. Such plan shall provide for the development of services, dispersed geographically to the extent feasible, which shall minimize the need for out-of-state placements and promote the return of individuals currently placed out-of-state to enhance family involvement and promote community reintegration.

3. The department shall, to the extent feasible, utilize existing organizations with demonstrated interest and expertise in serving persons with traumatic brain injuries and shall, within funds available, enter into contracts with such organizations.

§ 2744. The traumatic brain injury services coordinating council. 1.

The traumatic brain injury services coordinating council is hereby established and shall consist of the following persons or their designees: the commissioner, the commissioner of the office for people with developmental disabilities, the office of mental health, the commissioner of education, the commissioner of alcoholism and substance abuse services, the commissioner of social services, the state advocate for the disabled and the commission on quality of care for the mentally disabled. In addition, the council shall consist of the following persons: five persons appointed by the governor, three of whom shall be persons with traumatic brain injury and two of whom shall be representative of the public and have a demonstrated expertise and interest in traumatic brain injury; two persons appointed by the temporary president of the senate, one of whom shall be a person with traumatic brain injury and one of whom shall be representative of the public and have a demonstrated expertise and interest in traumatic brain injury; two persons appointed by the speaker of the assembly, one of whom shall be a person with traumatic brain injury and one of whom shall be representative of the public and have a demonstrated expertise and interest in traumatic brain injury, one person appointed by the minority leader of the senate who shall be a person with traumatic brain injury or be representative of the public and have a demonstrated expertise and interest in traumatic brain injury; and one person appointed by the minority leader of the assembly who shall be a person with traumatic brain injury or be representative of the public and have a demonstrated expertise and interest in traumatic brain injury. Of the five persons appointed by the governor, three shall serve for a term of one year, one shall serve for a term of two years and one shall serve for a term of three years. Of the two persons appointed by the temporary president of the senate, one shall serve for a term of two years and one shall serve for a term of three years. Of the two persons appointed by the speaker of the assembly, one shall serve for a term of two years and one shall serve for a term of three years. The person appointed by the minority leader of the senate and the person appointed by the minority leader of the assembly shall serve for a term of one year. Subsequent appointments for vacancies shall be for a term of three years and shall be filled in the same manner as the original appointment.

2. (a) The council shall be charged with recommending to the department long range objectives, goals and priorities. It shall also provide advice on the planning, coordination and development of needed services. In making such recommendations, the council shall consider:

(i) the availability and accessibility of services for individuals diagnosed with traumatic brain injury, the cost of receiving such services, and any disparities that may exist in the regional availability of services;

(ii) emerging trends in traumatic brain injury, including changes in incidences, changes in the needs of individuals with traumatic brain injury, and assess the training service providers receive relating to traumatic brain injury;

(iii) the difference in services availability and outcomes for individuals that may be enrolled in any Medicaid waiver; and

(iv) the efficiency of the administrative processes that provide individuals with traumatic brain injury official approvals or denials of service.

(b) The council shall post the recommendations developed pursuant to paragraph (a) of this subdivision on the department's website on or before one year from the date this paragraph shall take effect and annually thereafter.

3. The members of the council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties hereunder, subject to the approval of the commissioner.

4. (a) Within the traumatic brain injury services coordinating council there shall be established a concussion management advisory committee which shall develop recommendations specific to concussion management, academic scholarship, and public awareness for submission to the traumatic brain injury services coordinating council for consideration. The committee shall consist of members appointed from the membership of the traumatic brain injury services coordinating council by a majority vote of the council. Additional committee members may be appointed by the commissioner and shall have demonstrated experience with or expertise in one of the following areas: public health expertise related

to mild traumatic brain injuries and concussions, academic research in the area of traumatic brain injuries and concussion management, and public awareness experience related to the recognition of mild traumatic brain injuries and concussions. Committee membership shall not exceed twelve members. The committee may consult with a member or members of the public who have demonstrated expertise and interest in mild traumatic brain injuries and concussions.

(b) The recommendations of the advisory committee shall include, but not be limited to:

(i) methods to raise public awareness of mild traumatic brain injuries and concussions;

(ii) the development of outreach services to provide coordinated information regarding the recognition and management of mild traumatic brain injuries and concussions; and

(iii) the development of a clearinghouse of academic research and scientific findings related to the recognition, management, and treatment of mild traumatic injuries and concussions.

ARTICLE 27-CCC

LEUKEMIA, LYMPHOMA AND MYELOMA RESEARCH, EDUCATION AND TREATMENT PROGRAM

Section 2747. Leukemia, lymphoma and myeloma research, education and treatment.

§ 2747. Leukemia, lymphoma and myeloma research, education and treatment. The commissioner shall establish within the department a program to promote research, education and treatment regarding leukemia, lymphoma and myeloma. To carry out the purposes of this section, the commissioner shall have the following powers and duties:

1. to promote research, education and treatment programs designed to reduce or prevent the incidence and severity of leukemia, lymphoma and myeloma;

2. to accept and expend any grants, awards or other funds or appropriations as may be available for these purposes subject to

limitations as to the approval of expenditures and audit as prescribed for state funds by the state finance law; and

3. to enter into contracts within the amounts available therefor as may be necessary to implement the provisions of this section.

ARTICLE 27-D

NEW YORK STATE BURNS CARE INSTITUTE

Section 2750. Legislative findings and purpose.

2751. New York state burns care institute; organization.

2752. Functions, powers and duties.

§ 2750. Legislative findings and purpose. One of the three major causes of accidental death in New York state is burn injury, and one of the contributing factors to the high mortality rate from burn injuries is the lack of trained individuals and available facilities for the treatment and rehabilitation of the victims of burn injury. In order to provide for the improved delivery of medical care to the victims of burn injury in the state, the department of health shall have the central and comprehensive responsibility for the development and administration of the state's policy with respect to medical care of victims of burn injury.

§ 2751. New York state burns care institute; organization. 1. The New York state burns care institute is hereby created within the department of health.

2. The commissioner shall appoint a director of the institute and may employ such assistants and personnel as are necessary to carry out the provisions of this article.

§ 2752. Functions, powers and duties. In order to further the declared purposes of this article, the institute shall have the

following functions, powers and duties:

1. To contract with such regional burns care centers as the commissioner may determine, and on connection therewith, to:
 - (a) conduct scientific investigations of methods of treatment of burn injuries and rehabilitation of burn injury victims, such investigations to be primarily conducted as clinical research investigations; and to
 - (b) conduct a program of professional education and training in the treatment of burn injury and the rehabilitation of victims of burn injury for medical students, physicians, nurses and ambulance attendants located in the vicinities of the central and regional burns treatment centers.
2. To determine the need for and coordinate and supervise the establishment and operation of such regional and local burns treatment centers as are necessary in the state.
3. To develop and supervise programs of professional education and training in the treatment of burn injury and the rehabilitation of victims of burn injury for medical students, physicians, nurses and ambulance attendants in regional and local burns treatment centers.
4. To gather data and statistics and conduct investigations and research relating to the causes and prevention of burn injuries and the treatment of burn injury victims including the methods and procedures for their rehabilitation, and to disseminate information and conduct educational programs as to such causes, prevention and treatment.
5. To enter into such contracts and agreements with individuals, colleges, universities, associations, corporations, municipalities and other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of this article. Such contracts may provide for payment by the state for materials, equipment or services.
6. The commissioner may adopt such rules and regulations as are necessary to effectuate the purposes and provisions of this article.

ARTICLE 27-DD

STATE ADVISORY PANEL ON HIV/HBV INFECTED HEALTH CARE WORKERS

Section 2760. Advisory panel established.

2761. Function, powers and duties.

§ 2760. Advisory panel established. 1. A state advisory panel for the evaluation of health care workers with human immunodeficiency virus (HIV) or hepatitis B (HBV) (hereinafter referred to in this article as HIV/HBV) is hereby established in the department. This panel shall be known as the health care worker HIV/HBV advisory panel and shall be composed of three to five members. The commissioner shall appoint three members for a term of two years: a state or local public health officer, an infectious disease expert and an expert in infection control or epidemiology. For the purpose of the panel's deliberations on a specific case: (a) the commissioner may appoint a health professional with expertise relevant to procedures performed by the health care worker, provided, however, that the commissioner shall appoint such professional if the health care worker so requests; and (b) the commissioner shall, at the health care worker's request, appoint the health care worker's personal physician. The commissioner shall appoint the chairperson of the panel. A vacancy occurring during a term shall be filled by appointment by the commissioner for the unexpired term. Any member may be removed from the panel at the pleasure of the commissioner.

2. Each member of the panel shall receive up to one hundred fifty dollars as prescribed by the commissioner for each day devoted to panel work not to exceed forty-five hundred dollars in any one year, and shall be reimbursed for actual and necessary expenses incurred in the performance of his/her duties.

3. The department shall advise the panel members of statutory and regulatory confidentiality provisions and restrictions on disclosure of information which are applicable to the panel members and to panel operations.

§ 2761. Function, powers and duties. 1. The health care worker HIV/HBV advisory panel shall only evaluate and advise an HIV/HBV infected health care worker who voluntarily seeks the panel's review of the risk of HIV/HBV transmission to others through his/her workplace practice. Prior to the panel's evaluation of the worker, the panel must fully advise the worker of the panel's authority to investigate, to recommend practice restrictions or modifications, to advise facilities of such restrictions and to refer cases to professional licensing, registration and certification boards. If the health care worker is affiliated with or employed at a facility licensed by the department, the panel may evaluate and advise the worker only after such facility has completed its review of the scope of practice of the worker. This institutional review may be conducted through the facility's existing quality assurance program as required under section twenty-eight hundred five-j of this chapter, and need not require the creation of a separate facility HIV/HBV panel. Notwithstanding any other provision of law, rule or regulation, the panel may request and shall be entitled to receive patient records and other documents or information reasonably necessary for and relevant to the panel's deliberations and the implementation of this article including information and reports available to the department under section twenty-eight hundred five-m of this chapter, provided that the panel may only request records with patient names if essential to the panel's complete review of the case and provided further that employees of the department, other than the panel, shall redact patient names before panel review of such records. Any such information and reports provided to the panel that are subject to section two thousand eight hundred five-m of this chapter shall remain subject to the limitations on disclosure provided by such section. The panel may seek the advice of professionals with relevant expertise. The panel shall give the health care worker an opportunity to meet with the panel. The health care worker may be accompanied by a union or other representative at such meeting. Only when evidence indicates that the health care worker's practice poses a significant risk of harm to patients, the panel shall make appropriate recommendations that are least restrictive with respect to the health care worker's practice

including, but not limited to, training or monitoring, or, if necessary, reassignment or practice restrictions.

2. The panel shall evaluate an HIV/HBV infected health care worker pursuant to comprehensive medical criteria, including:

(a) physical or mental condition that interferes with or is significantly likely to interfere with the worker's ability to perform assigned tasks or regular duties;

(b) lack of compliance with established guidelines to prevent transmission of disease and/or documentation or evidence of previous transmission of bloodborne pathogens;

(c) the appropriateness of techniques as related to performance of procedures; and

(d) any health condition that would pose a significant risk to others.

3. When the panel recommends training, monitoring, reassignment, any similar action, or practice restrictions, the health care worker shall provide written assurance to the panel that he/she has informed facilities licensed by the department where the worker provides patient care of the panel's recommendations and shall identify the person or persons at the facilities so informed. If the health care worker fails to inform facilities licensed by the department where he/she provides patient care of the panel's recommendations, the panel shall so notify such facilities. If the health care worker fails to comply with the panel's recommendations or compliance cannot be determined by the panel after reasonable effort, the panel shall disclose the nature of its recommendations to the professional licensing, registration or certification boards relevant to the health care worker. The panel may periodically monitor and reevaluate the worker, with the worker's consent, at a frequency and through a mechanism to be determined by agreement between the worker and the panel.

4. The information received by the panel, the record of deliberations of the panel, and the decisions of the panel are not disclosable pursuant to article six of the public officers law. If the health care worker fails to comply with the recommendations of the panel or compliance cannot be determined by the panel after reasonable effort,

information held by the panel, the panel's deliberations and recommendations may be disclosed to and utilized by the office of professional medical conduct, the office of professional discipline and appropriate disciplinary bodies. The meetings of the panel are not subject to article seven of the public officers law. The members of the panel are bound by article six-A of the public officers law (personal privacy protection law).

5. A health care worker's petition to the panel shall not prevent or preclude the worker from seeking relief in any other forum at any time.

6. The commissioner may promulgate regulations implementing this article.

ARTICLE 27-E

THE ACQUIRED IMMUNE DEFICIENCY SYNDROME INSTITUTE

Section 2775. The acquired immune deficiency syndrome institute.

2776. Powers and duties.

2777. Research council.

2778. Advisory council.

2779. Reports by the commissioner.

§ 2775. The acquired immune deficiency syndrome institute. 1. There is hereby established within the department of health the acquired immune deficiency syndrome institute. The institute shall have the central responsibility for administering the provisions of this article and otherwise coordinating the state's policies with respect to acquired immune deficiency syndrome.

2. The commissioner shall appoint a director of the institute and may assign such personnel within the amounts appropriated as is necessary to carry out the provisions of this article.

§ 2776. Powers and duties. 1. The institute shall have the following

powers and duties:

(a) to develop and promote scientific investigations into the cause, prevention, methods of treatment, and cure of the acquired diseases of immunosuppression;

(b) to develop and promote programs of professional education and training and improvements in instrumentation as necessary adjuncts to such scientific investigations;

(c) to develop and maintain a clearing house within the department for information collected on acquired immune deficiency syndrome, including a catalogue of the existing medical literature and the results of existing epidemiological studies;

(d) to develop and promote an outreach campaign directed toward targeted high risk populations to provide coordinated information regarding the treatment and counseling programs and sources of financial assistance available; and

(e) to promote the availability of supportive services for affected persons.

2. Personal data in any investigations, reports and information relating thereto shall be kept confidential and be afforded all of the protections provided by the provisions of paragraph (j) of subdivision one of section two hundred six of the public health law. The institute may, however, from time to time publish analyses of such scientific investigations in such a manner as to assure that the identities of the individuals concerned cannot be ascertained.

§ 2777. Research council. 1. There shall be established within the institute a research council composed of seven members to be appointed by the commissioner. The members shall be representative of recognized centers engaged in the scientific investigation of acquired immunosuppressive diseases.

2. The research council shall be responsible for making recommendations to the institute for the purpose of carrying out the provisions of paragraphs (a) and (b) of subdivision one of section twenty-seven hundred seventy-six of this article.

3. The council shall meet at least four times a year. Special meetings may be called by the chairman, and shall be called by him at the request of the commissioner.

4. The members of the council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties hereunder.

§ 2778. Advisory council. 1. There shall be established within the institute an advisory council composed of seventeen members who shall be appointed in the following manner: three shall be appointed by the temporary president of the senate and one by the minority leader of the senate; three shall be appointed by the speaker of the assembly and one by the minority leader of the assembly; nine shall be appointed by the governor. The governor shall designate the chairman of the advisory council. The members of the council shall be representative of the public, educational and medical institutions, local health departments and nonprofit organizations, including organizations providing services to high risk populations.

2. The advisory council shall be responsible for advising the commissioner with respect to the implementation of this article and shall make recommendations to the institute for the purpose of carrying out the provisions of paragraphs (c), (d) and (e) of subdivision one of section twenty-seven hundred seventy-six hereof.

3. The council shall meet at least four times a year. Special meetings may be called by the chairman, and shall be called by him at the request of the commissioner.

4. The members of the council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties hereunder.

§ 2779. Reports by the commissioner. The commissioner shall make a first preliminary report to the governor and the legislature of its findings, conclusions, and recommendations not later than December first, nineteen hundred eighty-three, a second preliminary report of its findings, conclusions and recommendations not later than March first, nineteen hundred eighty-four and a final report of its findings, conclusions and recommendations not later than March first, nineteen hundred eighty-five, and shall submit with its reports such legislative proposals as it deems necessary to implement its recommendations.

ARTICLE 27-F

HIV AND AIDS RELATED INFORMATION

Section 2780. Definitions.

2781. HIV related testing.

2781-a. Required offering of HIV related testing.

2782. Confidentiality and disclosure.

2783. Penalties; immunities.

2784. Applicability to insurance institutions and insurance support organizations.

2785. Court authorization for disclosure of confidential HIV related information.

2785-a. Court order for HIV related testing in certain cases.

2786. Rules and regulations; forms; report.

2787. Separability.

§ 2780. Definitions. As used in this article, the following terms shall have the following meanings:

1. "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the centers for disease control of the United States public health service.

2. "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

3. "HIV related illness" means any illness that may result from or may be associated with HIV infection.

4. "HIV related test or HIV related testing" means any laboratory test, tests or series of tests approved for the diagnosis of HIV.

4-a. "Rapid HIV test or testing" means any laboratory screening test or tests approved for detecting antibodies to HIV, that produce results in sixty minutes or less, and encompasses a confirmatory HIV related test if the screening test is reactive.

5. "Capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

6. "Protected individual" means a person who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.

7. "Confidential HIV related information" means any information, in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV related information, concerning whether an individual has been the subject of an HIV related test, or has HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

8. "Health or social service" means any public or private care, treatment, clinical laboratory test, counseling or educational service for adults or children, and acute, chronic, custodial, residential, outpatient, home or other health care provided pursuant to this chapter or the social services law; public assistance or care as defined in

article one of the social services law; employment-related services, housing services, foster care, shelter, protective services, day care, or preventive services provided pursuant to the social services law; services for the mentally disabled as defined in article one of the mental hygiene law; probation services, provided pursuant to articles twelve and twelve-A of the executive law; parole services, provided pursuant to article eight of the correction law; corrections and community supervision, provided pursuant to the correction law; detention and rehabilitative services provided pursuant to article nineteen-G of the executive law; and the activities of the health care worker HIV/HBV advisory panel pursuant to article twenty-seven-DD of this chapter.

9. "Release of confidential HIV related information" means a written authorization for disclosure of confidential HIV related information which is signed by the protected individual, or if the protected individual lacks capacity to consent, a person authorized pursuant to law to consent to health care for the individual. Such release shall be dated and shall specify to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information shall not be construed as a release of confidential HIV related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV related information and complies with the requirements of this subdivision.

10. "Contact" means an identified spouse or sex partner of the protected individual, a person identified as having shared hypodermic needles or syringes with the protected individual or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the commissioner.

11. "Person" includes any natural person, partnership, association, joint venture, trust, public or private corporation, or state or local government agency.

12. "Health facility" means a hospital as defined in section two thousand eight hundred one of this chapter, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory, or facility providing care or treatment to persons with a mental disability as defined in article one of the mental hygiene law.

13. "Health care provider" means any physician, nurse, provider of services for the mentally disabled as defined in article one of the mental hygiene law, or other person involved in providing medical, nursing, counseling, or other health care or mental health service, including those associated with, or under contract to, a health maintenance organization or medical services plan.

14. "Child" means any protected individual actually or apparently under eighteen years of age.

15. "Authorized agency" means any agency defined by section three hundred seventy-one of the social services law and, for the purposes of this article, shall include such corporations incorporated or organized under the laws of the state as may be specifically authorized by their certificates of incorporation to receive children for the purposes of adoption or foster care.

16. "Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefits society, agent, broker or other entity including, but not limited to, any health maintenance organization, medical service plan, or hospital plan which: (a) is engaged in the business of insurance; (b) provides health services coverage plans; or (c) provides benefits under, administers, or provides services for, an employee welfare benefit plan as defined in 29 U.S.C. 1002(1).

17. "Insurance support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution for insurance

transactions, including: (a) the furnishing of consumer reports or investigative consumer reports to an insurance institution for use in connection with an insurance transaction; or (b) the collection of personal information from insurance institutions or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material non-disclosure in connection with insurance underwriting or insurance claim activity. The following persons shall not be considered "insurance-support organizations" for the purposes of this article: government institutions, insurance institutions, health facilities and health care providers.

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

2. Prior to ordering the test, information shall be provided, either orally or by prominently displayed signage, by printed materials, by electronic means or other appropriate form of communication to the subject of an HIV related test or, if the subject lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the subject, explaining that:

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

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

healthy;

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

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

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

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

(g) the law requires that an individual be notified before an HIV-related test is performed, and that no test shall be performed over their objection; and

(h) pre- and post-exposure prophylaxis medications (PrEP and PEP) are available to protect persons at risk of HIV infection.

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

4. A health care provider who is not authorized by the commissioner to provide HIV related tests on an anonymous basis shall refer a person who requests an anonymous test to a test site which does provide anonymous testing. The provisions of this subdivision shall not apply to a health care provider ordering the performance of an HIV related test on an individual proposed for insurance coverage.

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

(a) in the case of a test indicating evidence of HIV infection, provide the subject of the test or, if the subject lacks capacity to consent, the person authorized pursuant to law to consent to health care for the subject with counseling or referrals for counseling: (i) for coping with the emotional consequences of learning the result; (ii) regarding the discrimination problems that disclosure of the result could cause; (iii) for behavior change to prevent transmission or contraction of HIV infection; (iv) to inform such person of available medical treatments; and (v) regarding the need to notify his or her contacts; and (vi) regarding pre- and post-exposure prophylaxis

medications available to sexual partners to prevent HIV infection.

(b) in the case of a test not indicating evidence of HIV infection, provide (in a manner which may consist of oral or written reference to information previously provided) the subject of the test, or if the subject lacks capacity to consent, the person authorized pursuant to law to consent to health care for the subject, with information concerning (i) the risks of participating in high risk sexual or needle-sharing behavior; and (ii) regarding pre- and post-exposure prophylaxis medications available to prevent HIV infection.

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

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

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

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

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

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

(e) in situations involving occupational exposures which create a significant risk of contracting or transmitting HIV infection, as

defined in regulations of the department and pursuant to protocols adopted by the department,

(i) provided that:

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

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

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

(ii) in which case

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

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

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

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

§ 2781-a. Required offering of HIV related testing. 1. Every individual age thirteen and older (or younger than thirteen if there is

evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in subdivision ten of section twenty-eight hundred one of this chapter or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under article twenty-eight of this chapter or from a physician, physician assistant, nurse practitioner, or midwife providing primary care shall in accordance with subdivision one of section two thousand seven hundred eighty-one of this article be offered an HIV related test unless the health care practitioner providing such services reasonably believes that (a) the individual is being treated for a life threatening emergency; or (b) the individual has previously been offered or has been the subject of an HIV related test (except that a test shall be offered if otherwise indicated); or (c) the individual lacks capacity to consent to an HIV related test.

2. As used in this section, "primary care" means the medical fields of family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification.

3. The offering of HIV related testing under this section shall be culturally and linguistically appropriate in accordance with rules and regulations promulgated by the commissioner.

4. This section shall not affect the scope of practice of any health care practitioner or diminish any authority or legal or professional obligation of any health care practitioner to offer an HIV related test or to provide services or care for the subject of an HIV related test.

§ 2782. Confidentiality and disclosure. 1. No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to the following:

(a) the protected individual or, when the protected individual lacks

capacity to consent, a person authorized pursuant to law to consent to health care for the individual;

(b) any person to whom disclosure is authorized pursuant to a release of confidential HIV related information;

(c) an agent or employee of a health facility or health care provider if (1) the agent or employee is permitted to access medical records, (2) the health facility or health care provider itself is authorized to obtain the HIV related information, and (3) the agent or employee provides health care to the protected individual, or maintains or processes medical records for billing or reimbursement;

(d) a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual, a child of the individual, a contact of the protected individual or a person authorized to consent to health care for such a contact;

(e) a health facility or health care provider, in relation to the procurement, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical education, research, therapy, or for transplantation to individuals;

(f) health facility staff committees or accreditation or oversight review organizations authorized to access medical records; provided that such committees or organizations may only disclose confidential HIV related information: (1) back to the facility or provider of a health or social service; (2) to carry out the monitoring, evaluation, or service review for which it was obtained; or (3) to a federal, state or local government agency for the purposes of and subject to the conditions provided in subdivision six of this section;

(g) a federal, state, county or local health officer when such disclosure is mandated by federal or state law;

(h) an authorized agency in connection with foster care or adoption of a child. Such agency shall be authorized to redisclose such information only pursuant to this article or in accordance with the provisions of subdivision eight of section three hundred seventy-two and section three hundred seventy-three-a of the social services law;

(i) third party reimbursers or their agents to the extent necessary to reimburse health care providers for health services; provided that,

where necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider;

(j) an insurance institution, for other than the purpose set forth in paragraph (i) of this subdivision, provided the insurance institution secures a dated and written authorization that indicates that health care providers, health facilities, insurance institutions, and other persons are authorized to disclose information about the protected individual, the nature of the information to be disclosed, the purposes for which the information is to be disclosed and which is signed by: (1) the protected individual; (2) if the protected individual lacks the capacity to consent, such other person authorized pursuant to law to consent for such individual; or (3) if the protected individual is deceased, the beneficiary or claimant for benefits under an insurance policy, a health services plan, or an employee welfare benefit plan as defined in 29 U.S.C. 1002(1), covering such protected individual;

(k) any person to whom disclosure is ordered by a court of competent jurisdiction pursuant to section twenty-seven hundred eighty-five of this article;

(l) an employee or agent of the department of corrections and community supervision, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the department's functions, powers and duties with respect to the protected individual, pursuant to section two hundred fifty-nine-a of the executive law;

(m) an employee or agent of the office of probation and correctional alternatives or any local probation department, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the office's or department's functions, powers and duties with respect to the protected individual, pursuant to articles twelve and twelve-A of the executive law;

(n) a medical director of a local correctional facility as defined in section forty of the correction law, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the medical director is authorized to access

records containing such information in order to carry out his or her functions, powers and duties with respect to the protected individual;

(o) an employee or agent of the commission of correction, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the commission's functions, powers and duties with respect to the protected individual, pursuant to article three of the correction law;

(p) an attorney appointed to represent a minor pursuant to the social services law or the family court act, with respect to confidential HIV related information relating to the minor and for the purpose of representing the minor. If the minor has the capacity to consent, the minor's attorney may not redisclose confidential HIV related information without the minor's permission. If the minor lacks capacity to consent, the minor's attorney may redisclose confidential HIV related information for the sole purpose of representing the minor. This paragraph shall not limit the ability of the minor's attorney to seek relief under section twenty-seven hundred eighty-five of this chapter.

(q) an executor or an administrator of an estate shall have access to the confidential HIV information of a deceased person as needed to fulfill his or her responsibilities/duties as an executor or administrator.

(r) qualified researchers for medical research purposes upon the approval of a research protocol by a human research review committee established and approved under the provisions of article twenty-four-A of this chapter or by an institutional review board established and approved under the provisions of 45 CFR part 46 or 42 USC 300 V-1, for the purpose of reviewing and monitoring research involving human subjects, provided that in no event shall any qualified researcher disclose information tending to identify the subjects of the research.

(s) an employee or agent of the board of correction of the city of New York, in accordance with paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, to the extent the employee or agent is authorized to access records containing such information in order to carry out the board's functions, powers and duties with respect to the protected individual, pursuant to the charter

of the city of New York.

2. A state, county or local health officer may disclose confidential HIV related information when:

(a) disclosure is specifically authorized or required by federal or state law; or

(b) disclosure is made pursuant to a release of confidential HIV related information; or

(c) disclosure is requested by a physician pursuant to subdivision four of this section; or

(d) disclosure is authorized by court order pursuant to the provisions of section twenty-seven hundred eighty-five of this article.

3. No person to whom confidential HIV related information has been disclosed pursuant to this article shall disclose the information to another person except as authorized by this article, provided, however, that the provisions of this subdivision shall not apply:

(a) to the protected individual; or

(b) to a natural person who is authorized pursuant to law to consent to health care for the protected individual; or

(c) to a protected individual's foster parent as defined in section three hundred seventy-one of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, for the purpose of providing care, treatment or supervision of the protected individual; or

(d) a prospective adoptive parent as specified in section three hundred seventy-three-a of the social services law and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article with whom a child who is the protected individual has been placed for adoption; or

(e) to a relative or other person legally responsible to whom a child who is the protected individual is to be placed or discharged pursuant to section ten hundred seventeen or ten hundred fifty-five of the family court act and subject to regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article, for the purpose of providing care, treatment or

supervision of the protected individual.

4. (a) A physician may disclose confidential HIV related information under the following conditions:

(1) disclosure is made to a contact, to a public health officer for the purpose of making the disclosure to said contact and pursuant to section twenty-one hundred thirty of this chapter; or

(2) the physician believes disclosure is medically appropriate and there is a significant risk of infection to the contact; and

(3) the physician has counseled the protected individual regarding the need to notify the contact; and

(4) the physician has informed the protected individual of his or her intent to make such disclosure to a contact, the physician's responsibility to report the infected individual's case pursuant to section twenty-one hundred thirty of this chapter and has given the protected individual the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health officer for the purpose of said disclosure. If the protected individual expresses a preference for disclosure by a public health officer, the physician shall honor such preference.

(5) If a physician chooses to make a notification pursuant to this section, he or she shall report to the municipal health commissioner or district health officer on his or her efforts to notify the contacts of the protected individual. Such report shall be in a manner and on forms prescribed by the commissioner and shall include the identity of the protected individual and any contacts as well as information as to whether the contacts were successfully notified.

(6) Within a reasonable time of receiving a report that a physician or his or her designated agent did not notify or verify notification of contacts provided by the protected individual, the health commissioner or district health officer of the municipality from which the report originates shall take reasonable measures to notify such contacts and otherwise comply with the provisions of this chapter.

(b) When making such disclosures to the contact, the physician or public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of learning the information and for changing

behavior to prevent transmission or contraction of HIV infection. The physician or public health officer shall not disclose the identity of the protected individual or the identity of any other contact. A physician or public health officer making a notification pursuant to this subdivision shall make such disclosure in person, except where circumstances reasonably prevent doing so.

(c) A physician or public health officer shall have no obligation to identify or locate any contact except as provided pursuant to title three of article twenty-one of this chapter.

(d) A physician may, upon the consent of a parent or guardian, disclose confidential HIV related information to a state, county, or local health officer for the purpose of reviewing the medical history of a child to determine the fitness of the child to attend school.

(e) A physician may disclose confidential HIV related information pertaining to a protected individual to a person (known to the physician) authorized pursuant to law to consent to health care for a protected individual when the physician reasonably believes that: (1) disclosure is medically necessary in order to provide timely care and treatment for the protected individual; and (2) after appropriate counseling as to the need for such disclosure, the protected individual will not inform a person authorized by law to consent to health care; provided, however, that the physician shall not make such disclosure if, in the judgment of the physician: (A) the disclosure would not be in the best interest of the protected individual; or (B) the protected individual is authorized pursuant to law to consent to such care and treatment. Any decision or action by a physician under this paragraph, and the basis therefor, shall be recorded in the protected individual's medical record.

5. (a) Whenever disclosure of confidential HIV related information is made pursuant to this article, except for disclosures made pursuant to paragraphs (a), (d) and (i) of subdivision one of this section or paragraph (a) or (e) of subdivision four of this section, such disclosure shall be accompanied or followed by a statement in writing which includes the following or substantially similar language: "This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any

further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure." An oral disclosure shall be accompanied or followed by such a notice within ten days.

(b) Except for disclosures made pursuant to paragraph (c) of subdivision one of this section, or to persons reviewing information or records in the ordinary course of ensuring that a health facility is in compliance with applicable quality of care standards or any other authorized program evaluation, program monitoring or service review, or to governmental agents requiring information necessary for payments to be made on behalf of patients or clients pursuant to contract or in accordance to law, a notation of all such disclosures shall be placed in the medical record of a protected individual, who shall be informed of such disclosures upon request; provided, however, that for disclosures made to insurance institutions such a notation need only be entered at the time the disclosure is first made.

6. (a) The provisions of this subdivision shall apply where a provider of a health or social service possesses confidential HIV related information relating to individuals who are recipients of the service, and a federal, state or local government agency supervises or monitors the provider or administers the program under which the service is provided.

(b) Confidential HIV related information relating to a recipient of such service may be disclosed in accordance with regulations promulgated pursuant to paragraph (a) of subdivision two of section twenty-seven hundred eighty-six of this article to an authorized employee or agent of such provider or government agency, when reasonably necessary for such supervision, monitoring, administration, or provision of such service. The term "authorized employee or agent", as used in this subdivision shall only include any employee or agent who would, in the ordinary course of business of the provider or government agency, have access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual.

7. Nothing in this section shall limit a person's or agency's responsibility or authority to report, investigate, or redisclose, child protective and adult protective services information in accordance with title six of article six and titles one and two of article nine-B of the social services law, or to provide or monitor the provision of child and adult protective or preventive services.

8. Confidential HIV related information shall be recorded in the medical record of the protected individual. The provisions of this section shall not prohibit the listing of acquired immune deficiency syndrome, HIV related illness or HIV infection in a certificate of death, autopsy report or related documents prepared pursuant to article forty-one of this chapter or other applicable laws, ordinances, rules or regulations relating to the documentation of cause of death, nor shall this section be construed to modify any laws, ordinances, rules or regulations relative to access to death certificates, autopsy reports or such other related documents. Under no circumstances shall confidential HIV related information be disclosable pursuant to article six of the public officers law. Notwithstanding the foregoing, confidential HIV information obtained pursuant to section 390.15 of the criminal procedure law or section 347.1 of the family court act by either court order or consent of the protected individual shall not be recorded in the medical record of the protected individual unless he or she consents to the recording of such information in a written statement containing the relevant information specified in subdivision two of section two thousand seven hundred eighty-one of this article.

9. Confidential HIV related information shall be disclosed upon the request of the health care worker HIV/HBV advisory panel, established pursuant to article twenty-seven-DD of this chapter, to the panel or its designee only when reasonably necessary for the evaluation of a worker who has voluntarily sought the panel's review.

§ 2783. Penalties; immunities. 1. Any person who shall:

(a) perform, or permit or procure the performance of, an HIV related

test in violation of section twenty-seven hundred eighty-one of this article; or

(b) disclose, or compel another person to disclose, or procure the disclosure of, confidential HIV related information in violation of section twenty-seven hundred eighty-two of this article; shall be subject to a civil penalty not to exceed five thousand dollars for each occurrence. Such penalty may be recovered in the same manner as the penalty provided in section twelve of this chapter.

2. Any person who willfully commits an act enumerated in subdivision one of this section shall be guilty of a misdemeanor and subject to the penalties provided in section twelve-b of this chapter.

3. There shall be no criminal sanction or civil liability on the part of, and no cause of action for damages shall arise against any physician, his or her employer, or a physician's designated agent, or health facility or health care provider with which the physician is associated, or public health officer, on account of:

(a) the failure to disclose confidential HIV related information to a contact or person authorized pursuant to law to consent to health care for a protected individual; or

(b) the disclosure of confidential HIV related information to a contact or person authorized pursuant to law to consent to health care for a protected individual, when carried out in compliance with this article; or

(c) the disclosure of confidential HIV related information to any person, agency, or officer authorized to receive such information, when carried out in good faith and without malice, and in compliance with the provisions of this article; or

(d) the municipal health commissioner or district health officer's failure to notify contacts pursuant to this chapter.

4. Any cause of action to recover damages based on a failure to provide information, explanations, or counseling prior to the execution of a written informed consent, or based on a lack of informed consent in the ordering or performance of an HIV related test in violation of this article shall be governed by the provisions of section two thousand

eight hundred five-d of this chapter.

§ 2784. Applicability to insurance institutions and insurance support organizations. Except for disclosure to third party reimbursers and insurance institutions pursuant to paragraphs (i) and (j) of subdivision one of section twenty-seven hundred eighty-two of this article and except for disclosures pursuant to section twenty-seven hundred eighty-five of this article, the provisions of this article shall not apply to insurance institutions and insurance support organizations, except that health care providers associated with or under contract to a health maintenance organization or other medical services plan shall be subject to the provisions of this article.

§ 2785. Court authorization for disclosure of confidential HIV related information. 1. Notwithstanding any other provision of law, no court shall issue an order for the disclosure of confidential HIV related information, except a court of record of competent jurisdiction in accordance with the provisions of this section.

2. A court may grant an order for disclosure of confidential HIV related information upon an application showing: (a) a compelling need for disclosure of the information for the adjudication of a criminal or civil proceeding; (b) a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains; (c) upon application of a state, county or local health officer, a clear and imminent danger to the public health; or (d) that the applicant is lawfully entitled to the disclosure and the disclosure is consistent with the provisions of this article.

3. Upon receiving an application for an order authorizing disclosure pursuant to this section, the court shall enter an order directing that all pleadings, papers, affidavits, judgments, orders of the court, briefs and memoranda of law which are part of the application or the decision thereon, be sealed and not made available to any person, except

to the extent necessary to conduct any proceedings in connection with the determination of whether to grant or deny the application, including any appeal. Such an order shall further direct that all subsequent proceedings in connection with the application shall be conducted in camera, and, where appropriate to prevent the unauthorized disclosure of confidential HIV related information, that any pleadings, papers, affidavits, judgments, orders of the court, briefs and memoranda of law which are part of the application or the decision thereon not state the name of the individual concerning whom confidential HIV related information is sought.

4. (a) The individual concerning whom confidential HIV related information is sought and any person holding records concerning confidential HIV related information from whom disclosure is sought shall be given adequate notice of such application in a manner which will not disclose to any other person the identity of the individual, and shall be afforded an opportunity to file a written response to the application, or to appear in person for the limited purpose of providing evidence on the statutory criteria for the issuance of an order pursuant to this section.

(b) The court may grant an order without such notice and opportunity to be heard, where an ex parte application by a public health officer shows that a clear and imminent danger to an individual whose life or health may unknowingly be at risk requires an immediate order.

(c) Service of a subpoena shall not be subject to this subdivision.

5. In assessing compelling need and clear and imminent danger, the court shall provide written findings of fact, including scientific or medical findings, citing specific evidence in the record which supports each finding, and shall weigh the need for disclosure against the privacy interest of the protected individual and the public interest which may be disserved by disclosure which deters future testing or treatment or which may lead to discrimination.

6. An order authorizing disclosure of confidential HIV related information shall:

(a) limit disclosure to that information which is necessary to fulfill

the purpose for which the order is granted; and

(b) limit disclosure to those persons whose need for the information is the basis for the order, and specifically prohibit redisclosure by such persons to any other persons, whether or not they are parties to the action; and

(c) to the extent possible consistent with this section, conform to the provisions of this article; and

(d) include such other measures as the court deems necessary to limit any disclosures not authorized by its order.

§ 2785-a. Court order for HIV related testing in certain cases. 1.

Notwithstanding any contrary provision of law or regulation, a state, county or local public health officer to whom an order or a consent for an HIV test is addressed or sent, in accordance with section 390.15 of the criminal procedure law or section 347.1 of the family court act, must cause HIV related testing to be administered to the subject named therein and, if the test is pursuant to court order, must immediately provide to the court that issued the order a written report specifying the date on which such test was completed. Such report to the court shall not, however, disclose the results of such test. Such officer must disclose the results of the testing to the victim indicated in the order or consent and must also disclose the results to the person tested, unless the person tested has been asked to but declines to authorize such disclosure to himself or herself.

2. At the time of communicating the test results to the subject or the victim, such public health officer shall directly provide the victim and person tested with (a) counseling or referrals for counseling for the purposes specified in subdivision five of section two thousand seven hundred eighty-one of this article; (b) counseling with regard to HIV disease and HIV testing in accordance with law and consistent with subdivision five of section two thousand seven hundred eighty-one of this article; and (c) appropriate health care and support services, or referrals to such available services. If at the time of communicating the test results, the person tested is in the custody of the department of corrections and community supervision, office of children and family

services, office of mental health or a local correctional institution, the counseling and services required by this subdivision may be provided by a public health officer associated with the county or facility within which the person tested is confined.

3. Unless inconsistent with this section, the provisions of this article regarding the confidentiality and disclosure of HIV related information shall apply to proceedings conducted pursuant to section 390.15 of the criminal procedure law or section 347.1 of the family court act.

§ 2786. Rules and regulations; forms; report. 1. The commissioner shall promulgate rules and regulations concerning implementation of this article for health facilities, health care providers and other persons to whom this article is applicable. The commissioner shall also develop standardized model forms to be used for informed consent for HIV related testing and for the release of confidential HIV related information and materials for pre-test counseling as required by subdivision three of section twenty-seven hundred eighty-one of this article, and for post-test counseling as required by subdivision five of section twenty-seven hundred eighty-one of this article. Persons, health facilities and health care providers may use forms for informed consent for HIV related testing, and for the release of confidential HIV related information other than those forms developed pursuant to this section, provided they contain information consistent with the standardized model forms developed by the commissioner. All forms developed or used pursuant to this section shall be written in a clear and coherent manner using words with common, everyday meanings. The commissioner, in consultation with the AIDS institute advisory council, shall promulgate regulations to identify those circumstances which create a significant risk of contracting or transmitting HIV infection; provided, however, that such regulations shall not be determinative of any significant risk determined pursuant to paragraph (a) of subdivision four of section twenty-seven hundred eighty-two or section twenty-seven hundred eighty-five of this article.

2. (a) Each state agency authorized pursuant to this article to obtain confidential HIV related information and the board of correction of the city of New York shall, in consultation with the department of health, promulgate regulations: (1) to provide safeguards to prevent discrimination, abuse or other adverse actions directed toward protected individuals; (2) to prohibit the disclosure of such information except in accordance with this article; (3) to seek to protect individuals in contact with the protected individual when such contact creates a significant risk of contracting or transmitting HIV infection through the exchange of body fluids, and (4) to establish criteria for determining when it is reasonably necessary for a provider of a health or social service or the state agency or a local government agency to have or to use confidential HIV related information for supervision, monitoring, investigation, or administration and for determining which employees and agents may, in the ordinary course of business of the agency or provider, be authorized to access confidential HIV related information pursuant to the provisions of paragraphs (l) and (m) of subdivision one and subdivision six of section twenty-seven hundred eighty-two of this article; and provided further that such regulations shall be promulgated by the chairperson of the commission of correction where disclosure is made pursuant to paragraphs (n) and (o) of subdivision one of section twenty-seven hundred eighty-two of this article.

(b) The department of health, in consultation with agencies referred to in paragraph (a) of this subdivision, shall submit a report to the legislature by December first, nineteen hundred eighty-nine, outlining the status and content of such regulations, their effect on the regulated facilities and the protected individuals served by them, the extent to which they conform with current medical and scientific knowledge on the transmissibility of HIV infection, and any recommendations for changes in said regulations.

§ 2787. Separability. If any section, clause or provision of this article shall be deemed by any court of competent jurisdiction to be unconstitutional or ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and

effective and no other section, clause or provision shall on account thereof be deemed invalid or ineffective.

* ARTICLE 27-G

ADULT CYSTIC FIBROSIS ASSISTANCE PROGRAM

Section 2795. New York state adult cystic fibrosis assistance program.

* Repealed March 31, 2027

*** § 2795. New York state adult cystic fibrosis assistance program. 1.** Subject to available appropriation for the purpose outlined in this article, the department shall establish an adult cystic fibrosis assistance program, which shall be known as the "New York State Adult Cystic Fibrosis Assistance Program", and which shall consist of administrative support services for the provision of financial assistance for services such as prescription drug costs, device costs, medical care services, behavioral health services, and insurance premiums for the treatment of cystic fibrosis disease and its conditions.

2. The commissioner shall enter into a contract for the operation and promotion of the adult cystic fibrosis assistance program subject to such terms and conditions as may be contained within such contract with an organization that has experience and expertise improving access to healthcare for patients who are underinsured by dispersing financial assistance grants to cover costs of essential treatments and medications. The contractor may subcontract as needed for the effective performance of the contract. All such subcontractors and the terms of such subcontracts shall be subject to approval by the commissioner.

3. The duties of the contractor shall include, but not be limited to, the following:

(a) verification of patient eligibility for financial assistance grants allowable pursuant to paragraph (b) of this subdivision. To be eligible for a financial assistance grant, a patient shall meet criteria determined by the department, which shall include but not be limited to,

requiring the patient:

- (i) be a New York state resident;
 - (ii) be at least twenty-one years of age or older;
 - (iii) have a diagnosis of cystic fibrosis; and
 - (iv) have some form of primary private health insurance or Medicare and is not eligible for state Medicaid, and shall maintain health insurance during the financial assistance award period;
- (b) review of financial assistance grant applications submitted by eligible patients for approval, for services including but not limited to prescription drug costs, device costs, medical care services, behavioral health services, and medical, vision and dental insurance premiums, for patient treatment of cystic fibrosis;
- (c) disbursement of grant funding for applications approved pursuant to paragraph (b) of this subdivision related to the care and treatment of cystic fibrosis not otherwise covered by a health insurance policy;
- (d) preparation and submission of a monthly report to the department. Such report shall include but not be limited to:
- (i) new grants, which is the number of new grant recipients for initial grant periods;
 - (ii) renewal grants, which is the number of renewal grant recipients for renewal grant periods;
 - (iii) total active grant recipient count, which is the total number of active grant recipients;
 - (iv) grant recipients by insurance type, which is the number of active grant recipients sorted by insurance type;
 - (v) program expenses, which is the total amount spent sorted by assistance type but does not include administration fees;
 - (vi) application outcomes report, which is the number of grant recipients who have become inactive, sorted by reason; and
 - (vii) allotment used, which is the total amount of copayment assistance provided to each grant recipient compared to what is currently used by the grant recipient.

* NB Repealed March 31, 2027

* ARTICLE 27-H

DIABETES RESEARCH AND EDUCATION PROGRAM

Section 2796*2. Special programs with respect to diabetes.

* NB There are two Article 27-H's

§ 2796. Special programs with respect to diabetes. The commissioner shall establish within the department a program to promote research and patient education regarding diabetes. To carry out the purposes of this section, the commissioner shall have the following powers and duties:

1. to promote scientific investigations with respect to the causes, prevention and treatment of diabetes;
2. to promote patient education programs designed to reduce or prevent the incidence and severity of diabetes;
3. to accept and expend any grants, awards or other funds or appropriations as may be available for these purposes subject to limitations as to the approval of expenditures and audit as prescribed for state funds by the state finance law; and
4. to enter into contracts within the amounts available therefor as may be necessary to implement the provisions of this section.

* ARTICLE 27-H

THE TICK-BORNE DISEASE INSTITUTE

Section 2797. Tick-borne disease institute.

2798. Powers and duties.

* NB There are 2 Article 27-H's

§ 2797. Tick-borne disease institute. 1. There is hereby established within the department the tick-borne disease institute. The institute shall have responsibility for administering the provisions of this article and otherwise coordinating the state's policies with respect to lyme disease and other tick-borne diseases.

2. The commissioner shall appoint a director to the institute and may assign such personnel within the amounts appropriated as is necessary to carry out the provisions of this article.

§ 2798. Powers and duties. The tick-borne disease institute established by section twenty-seven hundred ninety-seven of this article shall have the following powers and duties:

1. to develop and promote investigations into the cause, prevention, detection, spread, methods of treatment, and cure of tick-borne diseases; and

2. to develop and promote an outreach campaign directed toward targeted high-risk populations to provide coordinated information regarding the cause, prevention, detection, and treatment of tick-borne disease.

ARTICLE 27-K

NEW YORK WELLNESS WORKS

Section 2799-o. New York wellness works; program established.

2799-q. Participation in New York wellness works.

2799-r. Program evaluations and recommendations; reports and statewide conference on best practices.

§ 2799-o. New York wellness works; program established. 1. The New York wellness works program is hereby established as a partnership between the state and employers to encourage health screening, education and incentives tailored to employees' specific needs to help promote health and prevent disease.

2. Upon the commissioner's approval, and within the amount appropriated, the department shall make available grants for the purpose of enabling employers to develop and implement health promotion and disease prevention initiatives. Such initiatives may include, but shall

not be limited to:

(a) the compilation of individual or aggregate employee health profiles, on an individual voluntary basis, with recommendations and incentives for health promotion activities based on individual or aggregate health information; or

(b) specific screening, education and health incentives; or

(c) such other employer-based health promotion and disease prevention measures, including changes to the work environment and policy changes in the worksite, as the commissioner may approve in accordance with this article.

3. The department may contract with an organization or organizations for the administration of the program, in accordance with the criteria for participation in said program as set forth in section two thousand seven hundred ninety-nine-q of this article.

4. In addition to any amounts as may be appropriated for grants, the commissioner is authorized to seek and receive funds from philanthropic foundations and other sources to further support such purposes.

§ 2799-q. Participation in New York wellness works. The commissioner, in consultation with the advisory panel, shall establish criteria for implementation and operation of the New York wellness works program, which at a minimum shall include:

(a) applicant eligibility and selection criteria;

(b) program operating requirements and standards;

(c) employee safeguards.

§ 2799-r. Program evaluations and recommendations; reports and statewide conference on best practices. 1. Employers participating in the New York wellness works program pursuant to this article shall report to the commissioner on the findings, experience and benefits pursuant to such program.

2. The commissioner shall evaluate and report his or her findings

concerning the New York wellness works program, including but not limited to the health and cost benefits, and shall make recommendations for modifying, expanding or otherwise improving the program as well as recommendations for other health system improvements based on such program. Such report shall incorporate the information submitted pursuant to subdivision one of this section and shall be submitted to the governor, temporary president of the senate, speaker of the assembly and the school of public health and health professions at the university at Buffalo on or before February first, two thousand nine.

On or before May first, two thousand nine, and at least biennially thereafter, the commissioner in consultation with the advisory panel shall convene a statewide conference to further promote the sharing of best practices among employers and others in pursuit of the goals of the New York wellness works program.

ARTICLE 28

HOSPITALS

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| 2801. | Definitions. |
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- 2807-c. General hospital inpatient reimbursement for annual rate periods beginning on or after January first, nineteen hundred eighty-eight.
- 2807-d. Hospital assessments.
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- 2832. Violence prevention program.
- 2832-a. Emergency department security.

§ 2800. Declaration of policy and statement of purpose. Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, pursuant to section three of article seventeen of the constitution, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for

the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health-related service shall be subject to the provisions of this article.

§ 2801. Definitions. The following words or phrases, as used in this article, shall have the following meanings, unless the context otherwise requires:

* 1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, a rural emergency hospital under 42 USC 1395x(kkk), or successor provisions, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health, substance use disorder services or developmental disability services that can be provided by a provider of

primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article sixteen or article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

* NB Effective until the date that the rates of reimbursement for integrated behavioral health services are approved and certified by parties set forth in chapter 60 of 2026 § 8

* 1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, a rural emergency hospital under 42 USC 1395x(kkk), or successor provisions, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital

shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article shall be construed to limit the volume of primary care services that can be provided by a program licensed to provide integrated behavioral health services, as defined in section 36.08 of the mental hygiene law. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health, substance use disorder services or developmental disability services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of addiction services and supports and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article sixteen or article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of addiction services and supports and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter

fifty-six of the laws of two thousand twelve; or (c) require a provider licensed under section 36.08 of the mental hygiene law to obtain a license from the department.

* NB Effective on the date that the rates of reimbursement for integrated behavioral health services are approved and certified by parties set forth in chapter 60 of 2026 § 8

2. "Nursing home" means a facility providing therein nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, providing nursing care and health-related service, or either of them, to persons who are not occupants of the facility.

3. "Residential health care facility" means a nursing home or a facility providing health-related service.

4. (a) "Hospital service" means the preadmission, out-patient, in-patient and post discharge care provided in or by a hospital, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of prevention, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home-care nursing and other paramedical service, ambulance service, service provided by an intern or resident in training, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

(b) "Health-related service" means service in a facility or facilities which provide or offer lodging, board and physical care including, but not limited to, the recording of health information, dietary supervision and supervised hygienic services incident to such service.

5. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, extension or modification of a hospital, including its equipment; the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures and other actions necessary

thereto.

6. "Council" and "public health council" mean the public health and health planning council.

7. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the state or a political subdivision thereof.

8. "Caretaker" means a person appointed pursuant to the provisions of section twenty-eight hundred six-b of this article, to act as a fiduciary responsible to the court which appoints him for the conserving and preserving of the rights and property of the operator of a residential health care facility, while also preserving and providing for the rights of the patients in such facility to care appropriate to their needs in a clean and wholesome environment in accordance with applicable federal and state laws and regulations.

9. "Out-patient lodge" means a facility affiliated with an institution providing hospital service, which provides therein food and overnight lodging to the chronically ill undergoing out-patient treatment for cancer at such institution.

10. "General hospital" means a hospital engaged in providing medical or medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions or deformities. The term general hospital shall not include a residential health care facility, public health center, diagnostic center, treatment center, out-patient lodge, dispensary and laboratory or central service facility serving more than one institution.

11. "Midwifery birth center" means a hospital engaged principally in providing prenatal and obstetric care, where such services are provided principally by midwives.

12. "Facility fee" means any fee charged or billed by a hospital or by a health care professional authorized under title eight of the education law that is: (a) intended to compensate the hospital or health care professional for the operational expenses regardless of the modality through which the health care services are provided; and (b) separate and distinct from a professional fee. "Facility fee" shall not include any fee charged or billed by a residential health care facility.

13. "Health system" means a group of one or more hospitals and providers affiliated through ownership, governance, membership or other means.

14. "Provider" means an individual or entity, whether for profit or nonprofit, whose primary purpose is to provide professional health care services.

§ 2801-a. Establishment or incorporation of hospitals. 1. No hospital, as defined in this article, shall be established except with the written approval of the public health and health planning council. No certificate of incorporation of a business membership or not-for-profit corporation shall hereafter be filed which includes among its corporate purposes or powers the establishment or operation of any hospital, as defined in this article, or the solicitation of contributions for any such purpose, or two or more of such purposes, except with the written approval of the public health and health planning council, and when otherwise required by law of a justice of the supreme court, endorsed on or annexed to the certificate of incorporation. No articles of organization of a limited liability company established pursuant to the New York limited liability company law which includes among its powers or purposes the establishment or operation of any hospital as defined in this article, shall be filed with the department of state except upon the approval of the public health and health planning council.

2. With respect to the incorporation or establishment of any hospital, as defined in this article, the public health and health planning

council shall give written approval after all of the following requirements have been met. An application for approval of the proposed certificate of incorporation, articles of organization or establishment shall be filed with the public health and health planning council together with such other forms and information as shall be prescribed by, or acceptable to, the public health and health planning council. Thereafter, the public health and health planning council shall forward a copy of the proposed certificate or application for establishment, and accompanying documents, to the health systems agency, if any, having geographical jurisdiction of the area where the proposed institution is to be located. The public health and health planning council shall act upon such application after the health systems agency has had a reasonable time to submit their recommendations. At the time members of the public health and health planning council are notified that an application is scheduled for consideration, the applicant and the health systems agency shall be so notified in writing. The public health and health planning council shall afford the applicant an opportunity to present information in person concerning the application to a committee designated by the council. The public health and health planning council shall not take any action contrary to the advice of the health systems agency until it affords to the health systems agency an opportunity to request a public hearing and, if so requested, a public hearing shall be held. If the public health and health planning council proposes to disapprove the application it shall afford the applicant an opportunity to request a public hearing. The public health and health planning council may hold a public hearing on the application on its own motion. Any public hearing held pursuant to this subdivision may be conducted by the public health and health planning council, or by any individual designated by the public health and health planning council. Beginning on January first, nineteen hundred ninety-four, and each year thereafter, a complete application received between January first and June thirtieth of each year shall be reviewed by the appropriate health systems agency and the department and presented to the public health and health planning council for its consideration prior to June thirtieth of the following year and a complete application received between July first and December thirty-first of each year shall be reviewed by the appropriate health systems agency and the department presented to the

public health and health planning council for consideration prior to December thirty-first of the following year.

2-a. (a) Notwithstanding any provision of law to the contrary, the commissioner is authorized to approve a certificate of incorporation or articles of organization for establishment of a hospital, provided that: (i) the certificate of incorporation or articles of organization reflects solely a change in the form of the business organization of an existing entity which had been approved by the public health and health planning council or its predecessor; and (ii) every incorporator, stockholder, member, director and sponsor of the new entity shall have been an owner, partner, incorporator, stockholder, member, director or sponsor of the existing entity; and (iii) the distribution of ownership, interests and voting rights in the new entity shall be the same as in the existing entity; and (iv) there shall be no change in the operator of a hospital other than the form of its business organization, as a result of the approval of such certificate of incorporation or articles of organization. Any approval by the public health and health planning council of a person as an owner, incorporator, stockholder, member, director or sponsor in the existing entity shall be deemed to be approval for the same degree of participation in the new entity. If the proposal is acceptable to the commissioner an amended operating certificate shall be issued. In the event the commissioner determines that the proposed transfer is not approvable the application shall be referred to the public health and health planning council for its review and action. If the public health and health planning council proposes to disapprove the application, it shall afford the applicant an opportunity to request a public hearing and, if so requested, a public hearing shall be held. Any public hearing held pursuant to this subdivision may be conducted by the public health and health planning council, or by any individual designated by the public health and health planning council.

2-b. (a) This subdivision applies with respect to an application under this section relating to the incorporation or establishment of any nursing home, in addition to subdivision two of this section.

(b) The department shall provide notice, in writing or electronically, of an application for establishment to the state office of long-term

care ombudsman, within thirty days of acknowledgement of the application by the department. Thereafter, the state office of the long-term care ombudsman shall submit its recommendation to the department and to the public health and health planning council for consideration about such application. At the time members of such council are notified that an application is scheduled for consideration by a committee designated by the public health and health planning council, the department shall also notify the state office of the long-term care ombudsman, in writing or electronically.

(c) In the case of an application for establishment relating to an existing nursing home, the established operator and applicant shall provide notice of the application, in writing or electronically, to residents of the nursing home and their representatives and the staff of the nursing home, including their union representatives, within thirty days of acknowledgment of the application by the department. The established operator and applicant shall also immediately notify residents of the nursing home and their representatives and the staff of the nursing home, including their union representatives, when the established operator and applicant is notified that its application is scheduled for consideration by a committee designated by the public health and health planning council.

3. The public health and health planning council shall not approve a certificate of incorporation, articles of organization or application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the institution at the time and place and under the circumstances proposed, provided, however, that in the case of an institution proposed to be established or operated by an organization defined in subdivision one of section one hundred seventy-two-a of the executive law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need; (b) the character, competence, and standing in the community, of the proposed incorporators, directors, sponsors, stockholders, members or operators; with respect to any proposed incorporator, director, sponsor, stockholder, member or operator who is already or within the past ten years has been an incorporator, director,

sponsor, member, principal stockholder, principal member, or operator of any hospital, private proprietary home for adults, residence for adults, or non-profit home for the aged or blind which has been issued an operating certificate by the state department of social services, or a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by the department of mental hygiene, no approval shall be granted unless the public health and health planning council, having afforded an adequate opportunity to members of health systems agencies, if any, having geographical jurisdiction of the area where the institution is to be located to be heard, shall affirmatively find by substantial evidence as to each such incorporator, director, sponsor, principal stockholder or operator that a substantially consistent high level of care is being or was being rendered in each such hospital, home, residence, halfway house, hostel, or other residential facility or institution with which such person is or was affiliated; for the purposes of this paragraph, the public health and health planning council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to determine whether a substantially consistent high level of care has been rendered, provided, however, that there shall not be a finding that a substantially consistent high level of care has been rendered where there have been violations of the state hospital code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety or welfare of any patient or resident, and (ii) were recurrent or were not promptly corrected; (c) the financial resources of the proposed institution and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

3-a. Notwithstanding any other provisions of this chapter, the public health council is hereby empowered to approve the establishment, for demonstration purposes, of not more than one existing hospital within the geographical jurisdiction of each health systems agency established under the provisions of subdivision (c) of section twenty-nine hundred four of this chapter. The purposes of such hospitals shall be to offer and provide nursing home services, board and lodging to persons requiring such services within one hospital. The public health council

may approve the establishment of such hospitals without regard to the requirement of public need as set forth in subdivision three of this section.

3-b. (a) This subdivision applies to an application under this section relating to a nursing home, and applies in addition to subdivision three of this section.

(b) The application shall provide information as to the character, competence and standing in the community of every individual and entity of the applicant and specify the identity of every nursing home in which each of those individuals and entities is, or in the preceding seven years has held a controlling interest or has been a controlling person, principal stockholder or principal member; and the nature of that interest. As used in this subdivision, "individual and entity of the applicant" shall include but not be limited to an individual or entity that is a controlling person, principal stockholder, or principal member of the applicant. The council shall not approve the application unless it finds that each individual and entity, in relation to ownership of a nursing home located in the United States, for at least the previous seven years, demonstrated satisfactory character, competence and standing in the community and the nursing home provided a consistently high level of care. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to determine whether a consistently high level of care has or has not been rendered by an applicant at such nursing home. The council shall consider, at a minimum, the following occurrences to determine whether a consistently high level of care has been delivered at a facility, and shall require the applicant to disclose and provide an explanation for any of the following occurrences: (i) a facility that has earned a two-star rating or less by the federal centers for Medicare and Medicaid Services (CMS) (or a comparable rating under a successor CMS rating system); (ii) where there have been violations of the state or federal nursing home code, or other applicable rules and regulations, that threatened to directly affect the health, safety or welfare of any patient or resident, including but not limited to a finding of immediate jeopardy, or actual harm, and were recurrent or were not promptly corrected, including but not limited to repeat deficiencies for the same

or similar violations over a three year period or during the entire duration of ownership if less than three years, or any facility which has been in receivership; (iii) where a facility has closed as a result of a settlement agreement from a decertification action or licensure revocation; or (iv) has been involuntarily terminated from the Medicare or Medicaid program in the prior five years, provided however, that where an applicant has taken over a facility and promptly corrected such deficiencies, the council may consider the application.

4. (a) Any change in the person who is the operator of a hospital shall be approved by the public health and health planning council in accordance with the provisions of subdivisions two and three of this section. Notwithstanding any inconsistent provision of this paragraph, any change by a natural person who is the operator of a hospital seeking to transfer part of his or her interest in such hospital to another person or persons so as to create a partnership shall be approved in accordance with the provisions of paragraph (b) of this subdivision.

(b) (i) Any transfer, assignment or other disposition of ten percent or more of an interest or voting rights in a partnership or limited liability company, which is the operator of a hospital to a new partner or member, shall be approved by the public health and health planning council, in accordance with the provisions of subdivisions two and three of this section, except that: (A) any such change shall be subject to the approval by the public health and health planning council in accordance with paragraph (b) of subdivision three of this section only with respect to the new partner or member, and any remaining partners or members who have not been previously approved for that facility in accordance with such paragraph, and (B) such change shall not be subject to paragraph (a) of subdivision three of this section.

(ii) With respect to a transfer, assignment or disposition involving less than ten percent of an interest or voting rights in such partnership or limited liability company to a new partner or member, no prior approval of the public health and health planning council shall be required. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the partnership or limited liability company fully completes and files with the public health and health planning council notice on a form, to be

developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction for any of the reasons set forth in item (A), (B), (C) or (D) below. Within ninety days from the date of receipt of such notice, the public health and health planning council may bar any transaction under this subparagraph: (A) if the equity position of the partnership or limited liability company, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition; (B) if the transaction would result in the ownership of a partnership or membership interest by any persons who have been convicted of a felony described in subdivision five of section twenty-eight hundred six of this article; (C) if there are reasonable grounds to believe that the proposed transaction does not satisfy the character and competence criteria set forth in subdivision three of this section; or (D) if the transaction, together with all transactions under this subparagraph for the partnership, or successor, during any five year period would, in the aggregate, involve twenty-five percent or more of the interest in the partnership. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

(iii) With respect to a transfer, assignment or disposition of an interest or voting rights in such partnership or limited liability company to any remaining partner or member, which transaction involves the withdrawal of the transferor from the partnership or limited liability company, no prior approval of the public health and health planning council shall be required. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the partnership or limited liability company fully completes and files with the public health and health planning council notice on a form, to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction for the reason set forth below. Within ninety days from the date of receipt of such notice, the public health and health planning council may bar any

transaction under this subparagraph if the equity position of the partnership or limited liability company, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

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

disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction. Nothing in this paragraph shall be construed as permitting a person not previously approved by the public health and health planning council for that corporation to become the owner of ten percent or more of the stock of a corporation which is the operator of a hospital or which is a member of a limited liability company which is the owner of a hospital without first obtaining the approval of the public health and health planning council.

(d) No hospital shall be approved for establishment which would be operated by a limited partnership, or by a partnership any of the members of which are not natural persons.

(e) No hospital shall be approved for establishment which would be operated by a corporation any of the stock of which is owned by another corporation or a limited liability company if any of its corporate members' stock is owned by another corporation.

(f) No corporation shall be a member of a limited liability company authorized to operate a hospital unless its proposed incorporators, directors, stockholders or principal stockholders shall have been approved in accordance with the provisions of subdivision three of this section applicable to the approval of the proposed incorporators, directors or stockholders of any other corporation requiring approval for establishment.

(g) A natural person appointed as trustee of an express testamentary trust, created by a deceased sole proprietor, partner or shareholder in the operation of a hospital for the benefit of a person of less than twenty-five years of age, may, as the trustee, apply pursuant to subdivision two of this section for approval to operate or participate in the operation of a facility or interest therein which is included in the corpus of such trust until such time as all beneficiaries attain the age of twenty-five, unless the trust instrument provides for earlier termination, or such beneficiaries receive establishment approval in their own right, or until a transfer of the trust corpus is approved by

the public health and health planning council, in accordance with this subdivision and subdivisions two and three of this section, whichever first occurs. The public health and health planning council shall not approve any such application unless it is satisfied as to:

- (i) the character, competence and standing in the community of each proposed trustee operator pursuant to the provisions of paragraph (b) of subdivision three of this section; and

- (ii) the ability of the trustee under the terms of the trust instrument to operate or participate in the operation of the hospital in a manner consistent with this chapter and regulations promulgated pursuant thereto.

(h) A natural person appointed conservator pursuant to article eighty-one of the mental hygiene law, or a natural person appointed committee of the property of an incompetent pursuant to article eighty-one of the mental hygiene law or a sole proprietor, partner or shareholder of a hospital, may apply pursuant to subdivision two of this section for approval to operate a hospital owned by the conservatee or incompetent for a period not exceeding two years or until a transfer of the hospital is approved by the public health and health planning council in accordance with subdivisions two and three of this section, whichever occurs first. The public health and health planning council shall not approve any such application unless it is satisfied as to:

- (i) the character, competence and standing in the community of the proposed conservator operator or committee operator pursuant to the provisions of paragraph (b) of subdivision three of this section; and

- (ii) the ability of the conservator or committee under the terms of the court order to operate the hospital in a manner consistent with this chapter and regulations promulgated pursuant thereto.

(i) Upon recommendation by the commissioner, if the public health and health planning council finds by substantial evidence that an improper delegation of management authority by a governing authority or operator of a general hospital has occurred as defined by paragraph (g) of subdivision one of section twenty-eight hundred six-a of this article, the establishment approval of such hospital shall be subject to revocation or suspension.

5. Except as otherwise hereinafter provided, no county, city, town,

village or other governmental subdivision shall establish or create any agency concerned with the establishment of any hospital as defined in this article without securing the written approval of the public health and health planning council in accordance with the requirements and procedures of subdivisions two and three of this section with respect to certificates of incorporation, articles of organization and establishment, except that the requirements relating to the proposed incorporators, directors and sponsors shall not apply. The preceding shall not apply to the establishment of state hospitals by the state of New York or to the establishment of municipal hospitals by the city of New York.

6. No corporation having power to solicit contributions for charitable purposes shall be deemed to have authority to solicit contributions for any purpose for which the approval of the public health and health planning council is required, unless the certificate of incorporation specifically makes provision therefor, and the written approval of the public health and health planning council, or its predecessor is endorsed on or annexed to such certificate.

7. Where such approval has not been obtained the public health and health planning council may institute and maintain an action in the supreme court through the attorney general to procure a judgment dissolving and vacating or annulling the certificate of incorporation of

(a) any such corporation, or

(b) any corporation hereafter incorporated, the name, purposes, objects or the activities of which in any manner may lead to the belief that the corporation possesses or may exercise any of such purposes.

8. No corporation heretofore formed, having among its powers the power to solicit contributions for charitable purposes, may solicit or continue to solicit contributions for a purpose for which the approval of the public health and health planning council is required without the written approval of the public health and health planning council, except: (a) a corporation which, prior to June first, nineteen hundred seventy, had received the approval of the state board of social welfare of a certificate of incorporation containing such power; or (b) a

corporation, which prior to December first, two thousand ten, had received the approval of the public health council of a certificate of incorporation containing such power. If such approval is not obtained and the corporation continues to solicit or to receive contributions for such purpose or advertises that it has obtained such approval, the public health and health planning council may institute and maintain an action in the supreme court through the attorney general to procure a judgment dissolving and vacating or annulling the certificate of incorporation of any such corporation.

9. Only a natural person, a partnership or limited liability company may hereafter undertake to engage in the business of operating or conducting a hospital, as defined in this article, for profit, except that: (a) a person, partnership or corporation which owned and was operating a hospital on April fourth, nineteen hundred fifty-six, may continue to own and operate such hospital; (b) a business corporation may, with the approval of the public health council, and in accordance with the provisions of subdivisions two and three of this section, undertake to engage in the business of operating or conducting a hospital, as defined in this article for profit, provided that such corporation shall not discriminate because of race, color, creed, national origin or sponsor in admission or retention of patients; (c) a business corporation owning and operating a nursing home on May twenty-second, nineteen hundred sixty-nine, in accordance with applicable provisions of law, may continue to own and operate such nursing home; (d) a person who, or a partnership which, is operating a private proprietary nursing home in accordance with applicable provisions of law may, with the approval of the public health and health planning council, and in accordance with the provisions of subdivision three of this section and any rules and regulations thereunder form a business corporation to engage in the business of operating or conducting such nursing home, provided, however, that such corporation shall not discriminate because of race, color, creed, national origin or sponsor in admission or retention of patients; (e) a business corporation operating a nursing home, which corporation was formed with the approval of the state board of social welfare, may continue to own and operate such nursing home.

10. (a) The public health and health planning council, by a majority vote of its members, shall adopt and amend rules and regulations, to effectuate the provisions and purposes of this section, and to provide for the revocation, limitation or annulment of approvals of establishment.

(b) (i) No approval of establishment shall be revoked, limited or annulled without first offering the person who received such approval the opportunity of requesting a public hearing. (ii) The commissioner, at the request of the public health and health planning council, shall fix a time and place for any such hearing requested. (iii) Notice of the time and place of the hearing shall be served in person or mailed by registered mail to the person who has received establishment approval at least twenty-one days before the date fixed for the hearing. (iv) Such person shall file with the department, not less than eight days prior to the hearing, a written answer. (v) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of such order or determination.

11. Any person filing a proposed certificate of incorporation, articles of organization or an application for establishment of a residential health care facility for approval of the public health and health planning council shall file with the commissioner such information as may be prescribed by regulation, including, but not limited to, the following:

(a) The name and address and a description of the interest held by each of the following persons:

(i) any person, who directly or indirectly, beneficially owns any interest in the land on which the facility is located;

(ii) any person who, directly or indirectly, beneficially owns any interest in the building in which the facility is located;

(iii) any person who, directly or indirectly, beneficially owns any interest in any mortgage, note, deed of trust or other obligation secured in whole or in part by the land on which or building in which the facility is located; and

(iv) any person who, directly or indirectly, has any interest as lessor or lessee in any lease or sub-lease of the land on which or the building in which the facility is located.

(b) If any person named in response to paragraph (a) of this subdivision is a partnership or limited liability company, then the name and address of each partner or member.

(c) If any person named in response to paragraph (a) of this subdivision is a corporation, other than a corporation whose shares are traded on a national securities exchange or are regularly quoted in an over-the-counter market or which is a commercial bank, savings bank or savings and loan association, then the name and address of each officer, director, stockholder and, if known, each principal stockholder and controlling person of such corporation.

(d) If any corporation named in response to paragraph (a) of this subdivision is a corporation whose shares are traded on a national securities exchange or are regularly quoted in an over-the-counter market or which is a commercial bank, savings bank or savings and loan association, then the name and address of the principal executive officers and each director and, if known, each principal stockholder of such corporation.

* (e) Information pertaining to staffing, the source of staffing, and staff skill mix.

* NB Effective October 21, 2021

12. The following definitions shall be applicable to this section:

(a) "Controlling person" of any corporation, partnership, limited liability company or other entity means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership or membership interests, to direct or cause the direction of the management or policies of said corporation, partnership, limited liability company or other entity. Neither the commissioner nor any employee of the department nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a residential health care facility, shall, by reason of his or her official position, be deemed a controlling person of any corporation, partnership, limited liability

company or other entity, nor shall any person who serves as an officer, administrator or other employee of any corporation, partnership, limited liability company or other entity or as a member of a board of directors or trustees of any corporation be deemed to be a controlling person of such corporation, partnership, limited liability company or other entity as a result of such position or his or her official actions in such position.

(b) "Principal stockholder" of a corporation means any person who beneficially owns, holds or has the power to vote, ten percent or more of any class of securities issued by said corporation.

(c) "Principal member" of a limited liability company means any person who beneficially owns, holds or has the power to vote, ten percent or more interest determined by such member's share in the current profits of the limited liability company.

13. Any person who operates a hospital without the written approval of the public health and health planning council shall be liable to the people of the state for a civil penalty not to exceed ten thousand dollars for every such violation.

14. (a) The public health and health planning council may approve the establishment of not-for-profit rural health networks as defined in article twenty-nine-A of this chapter, pursuant to the provisions of subdivisions two and three of this section, except that the public health and health planning council shall not consider the public need for and financial resources and sources of future revenues of such networks which do not seek approval to operate a hospital. In addition to character and competence, the public health and health planning council may take into consideration available network plans.

(b) The board of directors or trustees of a not-for-profit rural health network shall be comprised of a representative or representatives of participating providers and members of the general public residing in the area served by such network.

15. (a) Diagnostic or treatment centers established exclusively to provide end stage renal disease services may be operated by corporations and limited liability companies formed under the laws of New York whose

stockholders or members, as applicable, are not natural persons if such corporations and limited liability companies and its principal stockholders and members, as applicable, and controlling persons comply with all applicable requirements of this section and demonstrate, to the satisfaction of the public health and health planning council, sufficient experience and expertise in delivering high quality end stage renal disease care. For purposes of this subdivision, the public health and health planning council shall adopt and amend rules and regulations, notwithstanding any inconsistent provision of this section, to address any matter it deems pertinent to the establishment and operation of diagnostic or treatment centers pursuant to this subdivision; provided that such rules and regulations shall include, but not be limited to provisions governing or relating to: (i) any direct or indirect changes or transfers of ownership interests or voting rights in such corporations and limited liability companies or their stockholders or members, as applicable, and provide for public health and health planning council approval of any change in controlling interests, principal stockholders, principal members, controlling persons, parent company or sponsors; (ii) oversight of the operator and its stockholders or members, as applicable, including local governance of the diagnostic or treatment centers; and (iii) relating to the character and competence and qualifications of, and changes relating to, the directors, managers and officers of the operator and its principal stockholders, principal members, controlling persons, parent company or sponsors.

(b) The following provisions of this section shall not apply to diagnostic or treatment centers operated pursuant to this subdivision: (i) paragraph (b) of subdivision three of this section, relating to stockholders and members; (ii) paragraph (c) of subdivision four of this section, relating to the disposition of stock or voting rights; and (iii) paragraph (e) of subdivision four of this section, relating to the ownership of stock or membership.

16. (a) The commissioner shall charge to applicants for the establishment of hospitals the following application fee:

- | | |
|---|---------|
| (i) For general hospitals: | \$3,000 |
| (ii) For nursing homes: | \$3,000 |
| (iii) For safety net diagnostic and treatment centers | |

as defined in paragraph (c) of this subdivision: \$1,000

(iv) For all other diagnostic and treatment centers: \$2,000

(b) An applicant for both establishment and construction of a hospital shall not be subject to this subdivision and shall be subject to fees and charges as set forth in section twenty-eight hundred two of this article.

(c) The commissioner may designate a diagnostic and treatment center or proposed diagnostic and treatment center as a "safety net diagnostic and treatment center" if it is operated or proposes to be operated by a not-for-profit corporation or local health department; participates or intends to participate in the medical assistance program; demonstrates or projects that a significant percentage of its visits, as determined by the commissioner, were by uninsured individuals; and principally provides primary care services as defined by the commissioner.

(d) The fees and charges paid by an applicant pursuant to this subdivision for any application for establishment of a hospital approved in accordance with this section shall be deemed allowable capital costs in the determination of reimbursement rates established pursuant to this article. The cost of such fees and charges shall not be subject to reimbursement ceiling or other penalties used by the commissioner for the purpose of establishing reimbursement rates pursuant to this article. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

17. (a) Diagnostic or treatment centers or other facilities managed and administered by a local health department for the purpose of providing limited health care services as defined by the commissioner may be operated by a local health department. Such facilities shall be referred to in this subdivision as "municipal limited health care service facilities".

(b) The commissioner shall promulgate regulations for municipal limited health care service facilities, which may be different from the regulations otherwise applicable to hospitals, including, but not limited to: designating or limiting the diagnoses and services that may be provided; employee health requirements; and requirements or guidelines for advertising and signage, disclosure of ownership

interests, informed consent, record keeping, referral for treatment, case reporting to the patient's primary care or other health care providers, design, construction, fixtures, and equipment.

§ 2801-b. Improper practices in hospital staff appointments and extension of professional privileges prohibited. 1. It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician, podiatrist, optometrist, dentist or licensed midwife staff membership or professional privileges in a hospital, or to exclude or expel a physician, podiatrist, optometrist, dentist or licensed midwife from staff membership in a hospital or curtail, terminate or diminish in any way a physician's, podiatrist's, optometrist's, dentist's or licensed midwife's professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant. It shall be an improper practice for a governing body of a hospital to refuse to act upon an application or to deny or to withhold staff membership or professional privileges to a podiatrist based solely upon a practitioner's category of licensure.

2. Any person claiming to be aggrieved by an improper practice as defined in this section may, by himself or his attorney, make, sign and file with the public health council a verified complaint in writing which shall state the name and address of the hospital whose governing body is alleged to have committed the improper practice complained of and which shall set forth the particulars thereof and contain such other information as may be required by the council.

3. After the filing of any such complaint, the public health council shall make a prompt investigation in connection therewith. In conducting such investigation, the public health council is authorized to receive reports from the governing body of the hospital and the complainant, as the case may be, and the furnishing of such information to the public health council, or by the council to the governing body or complainant,

shall not subject any person or hospital to any action for damages or other relief. Such information when received by the public health council, or its authorized representative, shall be kept confidential and shall be used solely for the purposes of this section and the improvement of the standards of patient care and patient welfare. The records of such proceedings shall not be admissible as evidence in any other action of any kind in any court or before any other tribunal, board, agency, or person. If the council shall determine after such investigation that cause exists for crediting the allegations of the complaint, the council shall promptly so advise the governing body of the hospital against which the complaint was made, and shall direct that such governing body make a review of the actions of such body in denying or withholding staff membership or professional privileges from the complainant physician, podiatrist, optometrist, dentist or licensed midwife or in excluding or expelling such physician, podiatrist, optometrist, dentist or licensed midwife from staff membership or in curtailing, terminating or in any way diminishing such physician's, podiatrist's, optometrist's, dentist's or licensed midwife's professional privileges in the hospital.

4. The provisions of this section shall not be deemed to impair or affect any other right or remedy.

§ 2801-c. Injunctions. The supreme court may enjoin violations or threatened violations of any provisions of this article; and it may enjoin violations of the regulations of the department adopted thereunder. Upon request of the public health council or the commissioner, the attorney general shall maintain an action in the supreme court in the name of the people of the state to enjoin any such violation. Notwithstanding any limitation of the civil practice law and rules, such court may, on motion and affidavit, and upon proof that such violation is one which reasonably may result in injury to any person, whether or not such person is a party to such action, grant a temporary injunction upon such terms as may be just, pending the determination of the action. No security on the part of the people of this state shall be required. In any action for injunction brought pursuant to this article,

any finding of the public health council or the commissioner or hearing officer designated by either shall be prima facie evidence of the fact or facts found therein.

§ 2801-d. Private actions by patients of residential health care facilities. 1. Any residential health care facility that deprives any patient of said facility of any right or benefit, as hereinafter defined, shall be liable to said patient for injuries suffered as a result of said deprivation, except as hereinafter provided. For purposes of this section a "right or benefit" of a patient of a residential health care facility shall mean any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority. No person who pleads and proves, as an affirmative defense, that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is asserted shall be liable under this section. For the purposes of this section, "injury" shall include, but not be limited to, physical harm to a patient; emotional harm to a patient; death of a patient; and financial loss to a patient.

2. Upon a finding that a patient has been deprived of a right or benefit and that said patient has been injured as a result of said deprivation, and unless there is a finding that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury to the patient, compensatory damages shall be assessed in an amount sufficient to compensate such patient for such injury, but in no event less than twenty-five percent of the daily per-patient rate of payment established for the residential health care facility under section twenty-eight hundred seven of this article or, in the case of a residential health care facility not having such an established rate, the average daily total charges per patient for said facility, for each day that such injury exists. In addition, where the deprivation of any

such right or benefit is found to have been willful or in reckless disregard of the lawful rights of the patient, punitive damages may be assessed.

3. A patient residing in a residential health care facility may also maintain an action pursuant to this section for any other type of relief, including injunctive and declaratory relief, permitted by law.

4. Any damages recoverable pursuant to this section, including minimum damages as provided by subdivision two of this section, may be recovered in any action which a court may authorize to be brought as a class action pursuant to article nine of the civil practice law and rules. The remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, the patient's legal representative, or the patient's estate at law or in equity or by administrative proceedings, including tort causes of action, and may be granted regardless of whether such other remedies are available or are sought. A violation of subdivision three of section twenty-eight hundred three-c of this article is not a prerequisite for a claim under this section. Exhaustion of any available administrative remedies shall not be required prior to commencement of suit hereunder.

4-a. Under this section, any action that may be brought, and any relief that may be sought or received, may be brought, sought or received in an appropriate case by the patient's legal representative or the patient's estate.

5. The amount of any damages recovered by a patient, in an action brought pursuant to this section shall be exempt for purposes of determining initial or continuing eligibility for medical assistance under title eleven of article five of the social services law and shall neither be taken into consideration nor required to be applied toward the payment or part payment of the cost of medical care or services available under said title eleven.

6. If judgment in an action maintained under this section is rendered in favor of the plaintiff, in its discretion the court may, if justice

requires, award attorneys' fees to the plaintiff based on the reasonable value of legal services rendered and payable by the defendant.

7. Any waiver by a patient or his legal representative of the right to commence an action under this section, whether oral or in writing, shall be null and void and without legal force or effect.

8. Any party to an action brought under this section shall be entitled to a trial by jury and any waiver of the right to a trial by a jury, whether oral or in writing, prior to the commencement of an action, shall be null and void, and without legal force or effect.

9. No insurance premium or part thereof paid by any residential health care facility which is attributable solely to insurance against liability pursuant to this section shall be allowed as a reimbursable cost for purposes of any proposed rate schedule for payments for hospital or health-related service which the commissioner shall determine and certify pursuant to section twenty-eight hundred seven of this chapter.

10. a. No person shall discriminate against any patient of a residential health care facility because such patient, or the patient's legal representative, has brought or caused to be brought any action pursuant to this section, or against any patient or employee of a residential health care facility because such patient or employee has given or provided or is to give or provide testimony or other evidence for purposes of such action.

b. Any patient who has reason to believe that he or she may have been discriminated against in violation of this subdivision may, within thirty days after such alleged violation occurs, file a complaint with the commissioner. The commissioner shall investigate any such complaint, and shall, if such complaint is deemed meritorious, serve upon the administrator of the subject facility, in his capacity as a representative of the facility, either by personal service or by certified mail addressed to the administrator in care of the facility, return receipt requested, a complaint stating the substance of the

alleged discrimination with reasonable particularity. A hearing shall be conducted in accordance with section twelve-a of this chapter within thirty days of the service of such complaint. The hearing officer shall make a report of his findings to the commissioner, who, if he determines that a violation of this subdivision has occurred, may grant whatever relief is necessary and appropriate to remedy the violation, including, but not limited to readmittance of patients wrongfully discharged. Any such order of the commissioner shall be appealable by a proceeding under article seventy-eight of the civil practice law and rules.

c. Whenever the commissioner has issued an order as provided in this subdivision he may apply to any court of competent jurisdiction for the enforcement of such order.

d. Any action taken by the commissioner in accordance with the provisions of this subdivision shall not be exclusive, and may be taken in conjunction with an action for a civil penalty for a violation of paragraph a of this subdivision, or any private civil action brought by an injured party, or both.

e. Any employee who has reason to believe that he or she may have been discriminated against in violation of this subdivision may bring a proceeding in accordance with the provisions of article fifteen of the executive law.

§ 2801-e. Voluntary residential health care facility rightsizing demonstration program. 1. The voluntary residential health care facility rightsizing demonstration program is intended to be a flexible and innovative approach to dealing with excess capacity in residential health care facilities due to changes in care delivery and other factors. The demonstration is designed to promote the development of less restrictive and less institutional long-term care programs and services; discourage inappropriate nursing home placements; generate medicaid savings to the state and localities; and assist residential health care facilities with the financial implications of declining occupancies.

2. Notwithstanding any inconsistent provision of law or regulation to the contrary, a residential health care facility, as defined in section twenty-eight hundred one of this article, may apply to temporarily decertify or permanently convert a portion of its existing certified beds to another type of program or service under the voluntary residential health care facility rightsizing demonstration program. The commissioner may approve temporary decertifications and permanent conversions of beds totaling no more than five thousand residential health care facility beds on a statewide basis under this program. Such approvals shall reflect, to the extent practicable, participation by a variety of residential health care facilities based on geography, size and other pertinent factors.

3. For this purpose, a residential health care facility may submit, in a format and within timeframes specified by the commissioner, an application to temporarily decertify beds, or to permanently convert beds under this demonstration. Each such application shall include an estimate of the cost savings to the Medicaid program that would result from the proposal within the applicant facility. The commissioner shall begin soliciting applications within one hundred eighty days of the effective date of this section, provided however that multiple solicitations for proposals may be issued. In considering such applications, the commissioner shall take into account:

- (a) the potential for improved quality of care and quality of life for consumers;

- (b) the likelihood that the proposal would result in cost savings to the Medicaid program;

- (c) residential health care facility capacity and estimated public need in the planning area in which the applicant is located;

- (d) the availability of less restrictive and less institutional long-term care programs and services, as defined in this section, in the planning area; and

- (e) the potential for improving the financial viability of the applicant facility or facilities.

4. Any reductions in the number of operational residential health care

facility beds resulting from this demonstration shall not be considered to create additional public need for residential health care facility beds under this article.

5. (a) Subject to the approval of the commissioner and the director of the budget, a residential health care facility may temporarily decertify beds for up to five years. Such beds will remain on the facility's license during and after the five-year period. Temporarily decertified beds may, with the prior approval of the commissioner and the director of the budget be reactivated in whole or in part at any time on or after one year after the effective date of temporary decertification by the facility and may be reactivated with the prior approval of the commissioner and the director of the budget after the five-year period has ended. A residential health care facility that reactivates temporarily decertified beds may not temporarily decertify such beds again during the demonstration. The commissioner may require the immediate reactivation of such beds if necessary to respond to emergency situations and/or facility closures. In the event the commissioner requires such reactivation, the prohibition on temporarily decertifying beds after a reactivation of beds shall not apply.

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of determining medical assistance payments by government agencies for residential health care facility services provided pursuant to title eleven of article five of the social services law for facilities that have temporarily decertified beds:

(i) the facility's capital cost reimbursement shall be adjusted to appropriately take into account the new bed capacity of the facility;

(ii) the facility's peer group assignment for indirect cost reimbursement shall be based on its total certified beds less the number of beds that have been temporarily decertified; and

(iii) the facility's vacancy rate shall be calculated on the basis of its total certified beds less the number of beds that have been temporarily decertified for purposes of determining eligibility for payments for reserved bed days for residents of residential health care facilities, provided, however, that such payments for reserved bed days for facilities that have temporarily decertified beds shall be in an amount that is fifty percent of the otherwise applicable payment amount

for such beds.

6. (a) Subject to the approval of the commissioner, a residential health care facility may permanently convert beds to less restrictive and less institutional long-term care beds, units or slots, including, but not limited to, assisted living program, adult care facility, adult day health care, long-term home health care program and managed long-term care demonstration beds, units or slots. For this purpose, residential health care facility beds may be converted to beds, units or slots in the selected program or service on a one-to-one or other ratio or basis. A residential health care facility that permanently converts beds under this subdivision relinquishes its license for the converted beds.

(b) If the facility seeks to permanently convert beds and neither the facility nor its sponsoring organization is licensed to provide the program or service, it must obtain the written approval of the public health council, if required, pursuant to section twenty-eight hundred one-a of this article or article thirty-six of this chapter to initiate the new program or service.

(c) The commissioner may, as necessary, waive existing methodologies for determining public need under this article, article thirty-six of this chapter and article seven of the social services law, as well as enrollment limitations under section forty-four hundred three-f of this chapter, to accommodate permanent conversions of beds to other programs or services on the basis that any such increases in capacity are linked to commensurate reductions in the number of residential health care facility beds.

(d) For purposes of adjusting the capital component of residential health care facility rates of payment determined pursuant to this article for facilities that have permanently converted beds, the commissioner shall appropriately take into account the new bed capacity of the facility.

7. No later than January first, two thousand seven, the commissioner shall provide the governor, the majority leader of the senate and the speaker of the assembly with a written evaluation of the program. Such evaluation shall address the overall effectiveness of the program in

reducing costs, encouraging placements in appropriate long-term care settings and enhancing the availability of less restrictive and less institutional long-term care programs and services, and contain recommendations relative to extending and/or expanding the program.

§ 2801-f. Residential health care facility quality incentive payment program. Subject to amounts appropriated for the residential health care facility quality incentive payment program, the department may make a payment to operators of residential health care facilities, located in social services districts which do not include a city with a population of over one million persons, that are in compliance with applicable statutes and regulations in order to enhance the quality of patient care and patient safety. Provided that prior to receiving quality incentive payment program funds, the facility shall submit an expenditure plan to the department. Such plan shall detail how the quality incentive payment program funds will be used to improve the physical environment of the facility or the quality of care and services rendered to residents.

§ 2801-g. Community forum on hospital closure. 1. No later than thirty days after the closure of a general hospital, the commissioner shall hold a public community forum for the purpose of obtaining public input concerning the anticipated impact of the general hospital's closure on access to health care services by members of the surrounding community, including but not limited to recipients of medical assistance for needy persons, the uninsured, and underserved populations, and options and proposals to ameliorate such anticipated impact. The commissioner shall afford community members, health care providers, labor unions, payers, businesses and consumers a reasonable opportunity to speak about relevant matters at such community forum.

2. No later than sixty days after holding a community forum pursuant to subdivision one of this section, the commissioner shall make available to the public on the department's website information regarding:

(a) the anticipated impact of the general hospital's closure on access

to health care services by members of the surrounding community, including but not limited to recipients of medical assistance for needy persons, the uninsured, and underserved populations;

(b) specific measures the department and other parties have taken or will take to ameliorate such anticipated impact; and

(c) any further recommendations regarding access to health care services in communities impacted by the general hospital's closure.

3. A community forum conducted pursuant to this section shall be held at a location within a reasonable proximity to the general hospital subject to closure, and shall be announced no less than ten days prior to the date of such community forum.

4. At least thirty days prior to a general hospital applying to the federal centers for medicare and medicaid services to convert from a general hospital with inpatients to a rural emergency hospital under 42 USC 1395x(kkk), or successor provisions, such hospital shall hold a public community forum for the purpose of obtaining public input concerning the anticipated impact of the hospital's closure of inpatient units, including but not limited to, the impact on recipients of medical assistance for needy persons, the uninsured, people with disabilities, and medically underserved populations, and options and proposals to ameliorate such anticipated impact. The hospital shall notify health care providers, labor unions, the congressional representative for the district in which the facility is located, the county executive of the county in which the facility is located, and the state senator and assembly member representing the area within which the facility is located of the date, time, and location of the community forum. The hospital shall afford all public participants a reasonable opportunity to speak about relevant matters at such community forum. Prior to any community forum and as soon as practicable, the hospital shall be required to:

(a) notify the office of mental health and the local director of community services in the event such general hospital has psychiatric inpatient beds licensed under article thirty-one of the mental hygiene law or designated pursuant to section 9.39 of the mental hygiene law, and

(b) notify the office of addiction services and supports in the event such general hospital has inpatient substance use disorder treatment programs or inpatient chemical dependence treatment programs licensed under article thirty-two of the mental hygiene law. The commissioner shall also accept comments submitted in writing at such public forum and by mail within at least two weeks following the community forum.

§ 2801-h. Personal caregiving visitors for nursing home residents during public health emergencies. 1. As used in this section, the following terms have the following meanings:

(a) "personal caregiving visitor" means a family member, close friend, or legal guardian of a resident designated by the resident or the resident's lawful representative to assist with personal caregiving or compassionate caregiving for the resident;

(b) "personal caregiving" means care and support of a resident by a personal caregiving visitor that is provided to benefit such resident's mental, physical, or social well-being;

(c) "compassionate caregiving" means personal caregiving that is provided in anticipation of the end of a resident's life or in the instance of significant mental, physical, or social decline or crisis of a resident;

(d) "resident" means a resident of a nursing home; in relation to a personal caregiving visitor, "resident" means the resident to whom the personal caregiving visitor has been designated to assist with personal caregiving or compassionate caregiving; and

(e) "visit" includes assisting with personal caregiving or compassionate caregiving for a resident.

2. During a public health emergency declared under section twenty-four or section twenty-eight of the executive law personal caregiving visitors may visit residents of nursing homes, in compliance with federal law and regulations and state regulations made under this section. Nursing homes shall admit any personal caregiving visitor who is in compliance with applicable requirements under this section.

3. The commissioner shall make regulations under this section which

shall:

(a) require nursing homes to allow personal caregiving visitors to visit residents subject to this section;

(b) set forth procedures for the designation of personal caregiving visitors by residents or resident's lawful representatives, which: (i) shall include documentation of each designated personal caregiving visitor in the facility records; (ii) shall include procedures to ensure that the preferences of the resident regarding the designation of a personal caregiving visitor are respected; and (iii) may include, in appropriate circumstances, requiring a health or mental health professional licensed or certified under the education law to state that the personal caregiving will substantially benefit the resident's mental, physical, or social well-being. A nursing home shall not require that the health professional be affiliated with such nursing home;

(c) set forth procedures for changing a personal caregiving visitor designation;

(d) provide that a resident shall be entitled to designate at least two personal caregiving visitors;

(e) provide that personal caregiving visitors shall be exempt from prohibitions on visiting residents at nursing homes, subject to the limitations and requirements of this section;

(f) set forth the circumstances under which visiting by personal caregiving visitors may be temporarily limited or suspended at a nursing home to protect the health, safety and welfare of residents, including, but not limited to, local infection rates, temporary inadequate staff capacity, or an acute emergency situation;

(g) require, at a minimum, that all personal caregiving visitors follow safety protocols which may include, but need not be limited to:

(i) testing for communicable diseases;

(ii) checking body temperature upon entry into the nursing home;

(iii) health screenings upon entry into the nursing home;

(iv) appropriate use of personal protective equipment;

(v) social distancing (except as necessary for personal caregiving by the personal caregiving visitor for the resident); and

(vi) any other requirement the department deems appropriate;

(h) set forth standards for frequency and duration of visits by personal caregiving visitors at nursing homes;

(i) set forth standards for limiting the total number of personal caregiving visitors for a resident and/or limiting the total number of personal caregiving visitors allowed to visit a nursing home at any one time based on the circumstances of the residents and the nursing home;

(j) require personal caregiving and compassionate caregiving to be documented in the resident's individualized comprehensive plan of care; and

(k) make appropriate provisions for compassionate caregiving.

4. The department shall post the requirements consistent with regulations, on its website, including any requirements as to time periods and region.

5. This section does not require the medical assistance program to cover personal caregiving or compassionate caregiving and such caregiving shall not be reimbursed under the medical assistance program.

6. This section does not relieve any nursing home, or nursing home operator or administrator, of any obligation or responsibility imposed by any other applicable law or regulation.

7. Nothing in this section shall be construed to limit access by any visitor to a facility that would otherwise be permitted under federal or state law or regulation.

§ 2802. Approval of construction. The construction of a hospital, whether public or private, incorporated or not incorporated, shall require the prior approval of the commissioner.

1. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the public health and health planning council and the health systems agency, if any, having geographical jurisdiction of the area where the hospital is located.

1-a. The following types of construction projects by a hospital possessing a valid operating certificate shall not require prior approval pursuant to this section, provided that a written notice has been submitted to the department together with, where appropriate, a written architect and/or engineering certification that the project meets the applicable statutes, codes and regulations specified in the certification statement and, where required by the department, the hospital shall implement a plan to protect patient safety during construction:

(a) correction of cited deficiencies, provided that the construction is limited to the correction of the deficiencies and is authorized by a plan of correction approved by the department;

(b) repair or maintenance, regardless of cost, including routine purchases and the acquisition of minor equipment undertaken in the course of a hospital's inventory control functions; provided that for projects under this paragraph with a total cost of up to six million dollars, no written notice shall be required;

(c) non-clinical infrastructure projects regardless of cost including, but not limited to, replacement of heating, ventilating and air conditioning systems, roofs, fire alarm and call bell systems, parking lots and elevators;

(d) one for one equipment replacements regardless of cost, including replacement of equipment with another piece of equipment used for similar purposes but employing current technology; and

(e) other projects as specified in regulations adopted by the council and approved by the commissioner.

1-b. The commissioner is authorized to waive any requirement for pre-opening certifications and/or surveys for construction projects approved in accordance with this section.

2. The commissioner shall not act upon an application for construction of a hospital until the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations, and unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment

(including the approval of the public health and health planning council pursuant to the provisions of this article) provided, however, that the commissioner may act upon an application for construction by an applicant possessing a valid operating certificate when the application qualifies for review without the recommendation of the council pursuant to regulations adopted by the council and approved by the commissioner, or as otherwise authorized by this section; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that, in the case of an application by a hospital established or operated by an organization defined in subdivision one of section four hundred eighty-two-b of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need.

2-a. The council shall afford the applicant an opportunity to present information in person concerning an application to a committee designated by the council.

2-b. Beginning on January first, nineteen hundred ninety-four, and each year thereafter, a complete application received between January first and June thirtieth of each year shall be reviewed by the appropriate health systems agency and the department and presented to the public health and health planning council for its consideration prior to June thirtieth of the following year and a complete application received between July first and December thirty-first of each year shall be reviewed by the appropriate health systems agency and the department and presented to the public health and health planning council for consideration prior to December thirty-first of the following year.

2-c. An application for the relocation of long-term ventilator beds from one residential health care facility to another residential health care facility with common ownership shall be subject, as determined by the commissioner, to either an administrative or limited review by the department. Common ownership shall be found when the ownership or controlling interest in the operator of each residential health care

facility is the same, provided the percentage of ownership interest of each owner may vary between the two facilities but must meet the whole in common ownership. For purposes of this subdivision, the commissioner, when making a determination of public need, may consider access to long-term ventilator beds in the affected portions of the health systems region, and the quality of care provided at the facilities with common ownership. At no time shall an application submitted pursuant to this subdivision result in a change in the total combined number of long-term ventilator and residential health care facility beds, including residential health care facility beds converted from transferred long-term ventilator beds, operated by the two facilities with common ownership.

3. Subject to the provisions of paragraph (b) of subdivision two, the commissioner in approving the construction of a hospital shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the proposed hospital construction;

(b) the need for special equipment in view of existing utilization of comparable equipment at the time and place and under the circumstances proposed;

(c) the possible economies and improvements in service to be anticipated from the operation of joint central services including, but not limited to laboratory, research, radiology, pharmacy, laundry and purchasing;

(d) the adequacy of financial resources and sources of future revenue; and

(e) whether the facility is currently in substantial compliance with all applicable codes, rules and regulations, provided, however, that the commissioner shall not disapprove an application solely on the basis that the facility is not currently in substantial compliance, if the application is specifically:

(i) to correct life safety code or patient care deficiencies;

(ii) to correct deficiencies which are necessary to protect the life, health, safety and welfare of facility patients, residents or staff;

(iii) for replacement of equipment that no longer meets the generally accepted operational standards existing for such equipment at the time it was acquired; and

(iv) for decertification of beds and services.

3-a. Review of applications from hospitals in epidemic areas and hospitals serving state correctional facilities to renovate or provide for capital improvement for the purpose of controlling the spread of tuberculosis infection may be approved by the commissioner, who to the extent practicable may, but shall not be required to, consider the recommendations of the health systems agency and the public health and health planning council for applications for which he grants approval. In such cases the commissioner shall take further measures necessary to expedite departmental reviews for such approval.

3-b. Review of applications from rural hospitals seeking approval in the swing bed program, authorized pursuant to section twenty-eight hundred three of this article, may be approved by the commissioner who, to the extent practicable, may consider the recommendations of the respective health systems agency. In such cases, the commissioner shall take further measures necessary to expedite departmental reviews for such approval.

3-c. An application shall state the proposed site or location of the proposed construction. Where the applicant changes the site or location after approval of the application, the commissioner may, subject to regulations under this article, approve the change upon a finding that the change is in the best interest of the service area. In making such determination, the commissioner may seek a review of the proposed change by the public health and health planning council and the health systems agency having geographical jurisdiction.

4. No government agency shall construct any hospital without securing the written approval of the commissioner in accordance with the applicable requirements and procedures of the preceding subdivisions.

5. If the commissioner proposes to disapprove an application for

construction of a hospital, he shall afford the applicant an opportunity to request a public hearing. The commissioner shall not take any action contrary to the advice of the health systems agency until he affords an opportunity to the agency to request a public hearing and, if so requested, a public hearing shall be held.

6. The commissioner, on his own motion, may hold a public hearing on an application for construction of a hospital.

7. (a) The commissioner shall charge to applicants for construction of hospitals the following fees and charges for administrative services so as to recover departmental costs in performing these functions. Each applicant for construction of a hospital shall pay to the department an application fee of two thousand dollars, provided, however, that diagnostic and treatment centers designated by the commissioner as safety net diagnostic and treatment centers, as defined in paragraph (c) of subdivision sixteen of section twenty-eight hundred one-a of this article, shall pay a fee of one thousand two hundred fifty dollars.

(b) At such time as the commissioner's written approval of the construction is granted, each applicant shall pay the following additional fee:

(i) for hospital, nursing home and diagnostic and treatment center applications that require approval by the council, the additional fee shall be fifty-five hundredths of one percent of the total capital value of the application, provided however that applications for construction of a safety net diagnostic and treatment center, as defined in paragraph (c) of subdivision sixteen of section twenty-eight hundred one-a of this article, shall be subject to a fee of forty-five hundredths of one percent of the total capital value of the application; and

(ii) for hospital, nursing home and diagnostic and treatment center applications that do not require approval by the council, the additional fee shall be thirty hundredths of one percent of the total capital value of the application, provided however that safety net diagnostic and treatment center applications, as defined in paragraph (c) of subdivision sixteen of section twenty-eight hundred one-a of this article, shall be subject to a fee of twenty-five hundredths of one percent of the total capital value of the application.

(c) The commissioner is authorized to establish reduced fees for applications subject to limited review, as described in regulation, that do not require review by the council.

(d) The fees and charges paid by an applicant pursuant to this subdivision for any application for construction of a hospital approved in accordance with this section shall be deemed allowable capital costs in the determination of reimbursement rates established pursuant to this article. The cost of such fees and charges shall not be subject to reimbursement ceiling or other penalties used by the commissioner for the purpose of establishing reimbursement rates pursuant to this article. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

§ 2802-a. Transitional care unit demonstration program. 1.

Notwithstanding any other provision of law to the contrary, the commissioner is authorized to approve up to eighteen general hospitals within the state to operate transitional care units by and within such general hospitals. For purposes of this section, "transitional care" shall mean sub acute care services provided to patients of a general hospital who no longer require acute care general hospital inpatient services, but continue to need specialized medical, nursing and other hospital ancillary services and are not yet appropriate for discharge.

2. In order to receive approval from the commissioner to operate a transitional care unit and to provide transitional care services, a general hospital shall file an application on forms prescribed by or acceptable to the commissioner.

(a) The commissioner shall act upon such applications in a manner consistent with section twenty-eight hundred two of this article provided that the commissioner may not waive review and recommendation by the public health and health planning council. In the public health and health planning council's evaluation of applications and the commissioner acting upon such applications, priority shall be given to applicants who have a memorandum of understanding or other cooperative agreement with one or more skilled nursing facilities located within

their service area. Further, in the public health and health planning council evaluating applications and the commissioner acting upon such applications, consideration shall also be given to the geographic distribution of applicants throughout the state, so that applications may be approved from the various geographic regions of the state.

(b) The care provided in a transitional care unit shall be limited in duration and designed to resolve a patient's sub acute care medical problems and result in the timely and appropriate discharge of such a patient to a home, residential health care facility or other appropriate setting.

(c) In order to be approved to operate a transitional care unit and to provide transitional care services, an applicant must comply with and meet all applicable requirements of and conditions of participation under title XVIII of the federal Social Security Act (Medicare).

3. The commissioner shall report to the governor and the legislature concerning the implementation of this section and the operation of transitional care units within three years after the effective date of this section.

§ 2802-b. Health equity impact assessments. 1. Definitions. As used in this section:

(a) "Application" means an application under this article for the construction, establishment, change in the establishment, merger, acquisition, elimination or substantial reduction, expansion, or addition of a hospital service or health-related service of a hospital that requires review or approval by the council or the commissioner, where the application is filed or submitted to the council, the commissioner or the department after this section takes effect. Provided, however, that an application for the change in the establishment, merger or acquisition of a hospital shall not be included in this definition if the application would not result in the elimination, or substantial reduction, expansion, addition or change in location of a hospital service or health related service of the hospital.

(b) "Project" means the construction, establishment, change in the

establishment, merger, acquisition, elimination, or substantial reduction, expansion, or addition of a hospital service or health-related service of a hospital that is the subject of an application.

(c) "Health equity impact assessment" or "impact assessment" means an assessment of whether, and if so how, a project will improve access to hospital services and health care, health equity and reduction of health disparities, with particular reference to members of medically underserved groups, in the applicant's service area.

(d) "Medically underserved group" means: low-income people; racial and ethnic minorities; immigrants; women; lesbian, gay, bisexual, transgender, or other-than-cisgender people; people with disabilities; older adults; persons living with a prevalent infectious disease or condition; persons living in rural areas; people who are eligible for or receive public health benefits; people who do not have third-party health coverage or have inadequate third-party health coverage; and other people who are unable to obtain health care.

2. (a) (i) Every application shall include a health equity impact assessment of the project. The health equity impact assessment shall be filed together with the application, and the application shall not be complete without the impact statement. The applicant shall promptly amend or modify the impact statement as necessary.

(ii) However, in the case of a diagnostic and treatment center whose patient population is over fifty percent combined patients enrolled in Medicaid or uninsured, a health equity impact assessment is not required unless the application includes a change in controlling person, principal stockholder, or principal member (as defined in section twenty-eight hundred one-a of this article) of the applicant.

(b) In considering whether and on what terms to approve an application, the commissioner and the council, as the case may be, shall consider the health equity impact statement.

3. Scope and contents of a health equity impact assessment. A health equity impact assessment shall include:

(a) A demonstration of whether, and if so how, the proposed project will improve access to hospital services and health care, health equity

and reduction of health disparities, with particular reference to members of medically underserved groups, in the applicant's service area.

(b) The extent to which medically underserved groups in the applicant's service area use the applicant's hospital or health-related services or similar services at the time of the application and the extent to which they are expected to if the project is implemented.

(c) The performance of the applicant in meeting its obligations, if any, under section twenty-eight hundred seven-k of this article and federal regulations requiring providing uncompensated care, community services, and access by minorities and people with disabilities to programs receiving federal financial assistance, including the existence of any civil rights access complaints against the applicant, and how the applicant's meeting of these obligations will be affected by implementation of the project.

(d) How and to what extent the applicant will provide hospital and health-related services to the medically indigent, Medicare recipients, Medicaid recipients and members of medically underserved groups if the project is implemented.

(e) The amount of indigent care, both free and below cost, that will be provided by the applicant if the project is approved.

(f) Access by public or private transportation, including applicant-sponsored transportation services, to the applicant's hospital or health-related services if the project is implemented.

(g) The means of assuring effective communication between the applicant's hospital and health-related service staff and people of limited English-speaking ability and those with speech, hearing or visual impairments handicaps if the project is implemented.

(h) The extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

(i) A review of how the applicant will maintain or improve the quality of hospital and health-related services including a review of:

(i) demographics of the applicant's service area;

(ii) economic status of the population of the applicant's service area;

(iii) physician and professional staffing issues related to the project;

(iv) availability of similar services at other institutions in or near the applicant's service area; and

(v) historical and projected market shares of hospital and health care service providers in the applicant's service area.

(j) The extent to which the availability and provision of reproductive health services and maternal health care in the applicant's service area will be affected if the project is implemented. Applicants shall demonstrate how the project will impact the delivery of statutorily protected reproductive health care, pursuant to section twenty-five hundred ninety-nine-aa of this chapter, and maternity services.

4. The health equity impact assessment shall be prepared for the applicant by an independent entity and include the meaningful engagement of public health experts, organizations representing employees of the applicant, stakeholders, and community leaders and residents of the applicant's service area.

5. The department shall publicly post the application and the health equity impact assessment on its website within one week of the filing with the department, including any filing with the council. The applicant shall publicly post the application and the health equity impact assessment on its website within one week of acknowledgement by the department.

§ 2803. Commissioner and council; powers and duties. 1. (a) The commissioner shall have the power to inquire into the operation of hospitals and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service, system of accounts, records, and the adequacy of financial resources and sources of future revenues. The commissioner or persons designated by him shall conduct at least one unannounced comprehensive inspection of each residential health care facility not later than fifteen months after the previous such inspection to determine the adequacy of care being rendered. Such comprehensive inspection shall include, but not be limited to, a survey to determine

compliance by the facility with applicable statutes and regulations, and observation of a representative sample of all patients or residents and their medical records to determine the quality and adequacy of the care and treatment provided. Additional visits shall be made to facilities as needed to determine whether violations or deficiencies have been corrected, to investigate any report made pursuant to section twenty-eight hundred three-d of this article or any other complaint, and for any other purpose deemed necessary and appropriate by the commissioner. Any employee of the department who gives or causes to be given advance notice of such unannounced inspection to any unauthorized person shall, in addition to any other penalty provided by law, be suspended by the commissioner from all duties without pay for at least five days or for such greater period of time as the commissioner shall determine. Any such suspension shall be made by the commissioner in accordance with all other applicable provisions of law.

(b) The purpose of such inspection shall be to determine compliance by residential health care facilities with statutes, and with regulations promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, rights of patients, rates of payment and reimbursement. At least one such inspection every fifteen months shall include, but shall not be limited to, full on-site examination of the medical, nursing care, dietary and social services records of the facility.

(c) The commissioner shall establish, in consultation with the state office for the aging, a consumer information system for residential health care facilities with respect to their compliance with the standards set forth in this section designed to provide accurate and comprehensible information to consumers on the quality of facilities which shall incorporate a summary of the findings and results of the inspections conducted pursuant to the provisions of this section. Such summary of results and findings shall include, but need not be limited to, a listing of areas in which items were found at the time of such inspections to be not in compliance with such standards and the nature of such non-compliance. Each residential health care facility shall be issued a summary of the findings of inspections of such facility conducted since the issuance of the previous summary of findings, which shall be posted conspicuously within such facility, and any other

information relating to the facility available through the consumer information system. The commissioner shall promulgate rules and regulations necessary to implement the provisions of this paragraph. A facility may appeal the accuracy of a summary findings to the commissioner within twenty days after receipt of such summary. The results and findings of any prior inspections, and any penalties thereby assessed, which have not been previously appealed and overruled, shall not be subject to review.

(d) (i) Notwithstanding any inconsistent provision of law, the commissioner or his designee shall determine the necessity and appropriateness of care and services provided by hospitals to patients eligible for medical assistance pursuant to title eleven of article five of the social services law and shall further determine whether a general hospital has taken an action that results in the admission of patients unnecessarily, unnecessary multiple admissions of the same patients, inappropriate discharge of patients, inappropriate transfer of patients between hospitals or between distinct units of a hospital, inappropriate diagnosis-related group coding, or other inappropriate medical or other practices with respect to hospitalized inpatients eligible for medical assistance pursuant to title eleven of article five of the social services law. In making such determinations the commissioner may utilize the services of department personnel or other authorized representatives. The hospitals shall provide such information, facilities and services as may be required by the commissioner to make such determinations. The commissioner, in implementing this paragraph, shall adopt necessary rules and regulations including but not limited to those for determining the necessity or appropriate level of admission, controlling the length of stay, the provision of surgery and other services, and the methods and procedures for making such determinations.

(ii) In the event the commissioner or his designee makes a determination pursuant to this paragraph that a general hospital or physician has taken an inappropriate action resulting in a denial or adjustment of payment determined in accordance with section twenty-eight hundred seven-c of this article, the general hospital or physician which is the subject of such determination shall be entitled to a review before the commissioner or an appeal agent designated for such purposes by the commissioner at which such hospital or physician may challenge

such determination. In order to be entitled to such review, such hospital or physician must provide the commissioner or his designee, as appropriate, with a written request for such review within thirty days of receipt of the written determination. During such review, the hospital or physician may present documentation or evidence in support of its challenge to the determination, and representatives of the commissioner or his designee may present documentation or evidence in support of the determination. In the event that the determination is sustained, the hospital or physician may seek judicial review of the decision pursuant to article seventy-eight of the civil practice law and rules.

(iii) The commissioner shall certify to the social services officials responsible for making payments for authorized hospital services that specified items of care and services for specified individuals eligible for medical assistance pursuant to title eleven of article five of the social services law are inappropriate or unnecessary and are not authorized for payment or are authorized for payment at the appropriate level of care under the medical assistance program and, for general hospitals, for rate periods beginning on or after January first, nineteen hundred eighty-eight through March thirty-first, nineteen hundred ninety-seven, at the appropriate case based rate of payment determined pursuant to section twenty-eight hundred seven-c of this article.

(e) Notwithstanding any inconsistent provision of law, the commissioner or his designee shall, not later than July first, nineteen hundred seventy-six, determine on an individual patient basis whether identifiable periods of in-patient care in a general hospital are required beyond the maximum length of stay established pursuant to section three hundred sixty-five-a of the social services law, and whether deferral of surgical procedures specified by such commissioner in accordance with paragraph (c) of subdivision five of such section may jeopardize life or essential function, or cause severe pain. In making such determinations the commissioner may utilize the services of department personnel or other authorized representatives. The hospitals shall provide such information, facilities and services as may be required by the commissioner to make such determinations. The commissioner, in implementing this paragraph, shall adopt necessary

rules and regulations including but not limited to the methods and procedures for making such determinations and the utilization of any department staff or other authorized representatives located at such hospital in performing other functions relating to assuring that public funds for medical assistance are utilized exclusively to provide items of care and services in amount, duration and scope specifically authorized under the medical assistance program. The commissioner shall certify to the social services officials responsible for making payments for authorized hospital services that specified items of care and services for specified individuals are not authorized for payment under the medical assistance program.

(f) Notwithstanding any inconsistent provision of law, the commissioner shall establish standards for determining the necessity of care and service for alcoholism and alcohol abuse provided by hospitals. In implementing this paragraph the commissioner, in consultation with the director of the division of alcoholism and alcohol abuse, shall adopt necessary rules and regulations including but not limited to those for determining the necessity or appropriate level of admission, controlling the length of stay, the provision of services and establishing the methods and procedures for making such determinations.

(g) The commissioner shall require that every general hospital adopt and make public an identical statement of the rights and responsibilities of patients, in accordance with applicable law, including, but not limited to:

(i) a patient complaint and quality of care review process;

(ii) a right to receive all information necessary to give informed consent for any proposed intervention, procedure, or treatment, including information regarding the foreseeable and clinically significant risks and benefits of the proposed intervention, procedure, or treatment;

(iii) a right to receive complete information regarding the patient's condition, prognosis, and clinical indications for the proposed intervention, procedure, or treatment;

(iv) a right to receive information regarding alternative treatment options including the foreseeable and clinically significant risks and benefits of such alternative treatment options, taking into consideration any known preconditions;

(v) a right to be informed of the name, position, and functions of any persons, including medical students and physicians exempt from New York state licensure pursuant to section sixty-five hundred twenty-six of the education law, who provide face-to-face care to or direct observation of the patient;

(vi) a right to refuse the proposed intervention, procedure, or treatment and to be informed of the clinical effects of such refusal;

(vii) a right to meaningfully engage and participate in the informed consent process, which shall mean, but not be limited to, affording the patient or their representative time to ask questions and have them answered satisfactorily to the extent reasonable;

(viii) a right to be informed of any human subjects research that the attending physician taking care of the patient participates in and may directly affect a procedure or treatment to be received by the patient, and to provide voluntary written informed consent to participate, should the patient be an appropriate candidate for such human subjects research in the clinical judgment of the attending physician. The informed consent referred to here shall conform with federal requirements regarding protection for human research subjects, and any other applicable laws or regulations;

(ix) a right to an appropriate patient discharge plan; and

(x) for patients other than beneficiaries of title XVIII of the federal social security act (medicare), a right to a discharge review in accordance with section twenty-eight hundred three-i of this article. The form and content of such statement shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner. A patient who requires continuing health care services in accordance with such patient's discharge plan may not be discharged until such services are secured or determined by the hospital to be reasonably available to the patient. Each general hospital shall give a copy of the statement to each patient, or the appointed personal representative of the patient at or prior to the time of admission to the general hospital, as long as the patient or the appointed personal representative of the patient receives such notice no earlier than fourteen days before admission. Such statement shall also be conspicuously posted by the hospital and shall be a part of the patient's admission package. Nothing herein contained shall be construed

to limit any authority vested in the commissioner pursuant to this article related to the operation of hospitals and care and services provided to patients.

* (h) Every hospital providing treatment to alleged victims of family offenses as defined in article eight of the family court act and section 530.11 of the criminal procedure law shall be responsible for providing a copy of a notice to victims of family offenses as described in section eight hundred twelve of the family court act and subdivision six of section 530.11 of the criminal procedure law. The commissioner shall promulgate such rules and regulations as may be necessary and proper to carry out effectively the provisions of this paragraph.

* NB There are 2 (h)'s

* (h) The statement regarding patient rights and responsibilities which the commissioner shall approve as provided under paragraph (g) of this subdivision shall include a provision stating that every patient shall have the right to authorize those family members and other adults who will be given priority to visit consistent with the patient's ability to receive visitors.

* NB There are 2 (h)'s

(i) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to make organ, tissue or whole body donations, and the means by which the patient may make such a donation. The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this paragraph.

* (j) As used with regard to applicable regulations issued by the department implementing the statement regarding patient rights and responsibilities required pursuant to paragraph (g) of this subdivision, the term "itemized bill" shall, for all periods on and after January first, two thousand eleven, be defined as reflecting a charges schedule developed by each hospital for all ancillary patient services, which schedule shall set forth separate charges for each ancillary service provided.

* NB There are 2 (j)'s

* (j) The commissioner shall require that the statement regarding patient rights and responsibilities, described in paragraph (g) of this subdivision, shall include a provision informing the patient of his or

her right to not be discriminated against on account of age.

* NB There are 2 (j)'s

(k) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to submit surprise bills or bills for emergency services to the independent dispute process established in article six of the financial services law, and informing the patient of his or her right to view a list of the hospital's standard charges and the health plans the hospital participates with consistent with section twenty-four of this chapter.

(l) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include provisions informing the patient of his or her right to choose to identify a caregiver pursuant to article twenty-nine-cccc of this chapter.

2. (a) The council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to:

(i) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization, and costs in accordance with section twenty-eight hundred three-b of this article,

(ii) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital and health-related services as provided in sections twenty-eight hundred seven, twenty-eight hundred seven-a, twenty-eight hundred seven-c and twenty-eight hundred eight of this article. The schedules established shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In adopting regulations related to the computation of general hospital inpatient payments, the council shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The council

shall exclude from consideration in the regulations adopted nonallowable costs such as the costs for research and those parts of the costs for educational salaries which the council determines to be not directly related to hospital service,

(iii) the identification of appropriate and reasonable standards for the development of acceptable collection procedures used by general hospitals in an effort to collect unpaid bills prior to the determination that the unpaid bill is a bad debt eligible for reimbursement consideration pursuant to paragraphs (e) and (f) of subdivision eight of section twenty-eight hundred seven-a or paragraph (b) of subdivision fourteen of section twenty-eight hundred seven-c and twenty-eight hundred seven-k of this article,

(iv) subject to the provisions of paragraph (e) of subdivision eleven of section twenty-eight hundred seven-a of this article or subdivision nine of section twenty-eight hundred seven-c of this article, the establishment of guidelines regarding the time to resolve appeals submitted by general hospitals. The council may consider different periods depending upon whether the basis for the appeal is related to a general hospital's existing costs or anticipated future costs,

(v) standards and procedures relating to hospital operating certificates, provided however, that the council shall establish minimum acceptable standards and procedures equal to the standards and procedures which federal law and regulation require for hospitals to qualify as providers pursuant to titles XVIII and XIX of the federal social security act. The existing state standards and procedures in effect on the date that this subdivision becomes effective shall be deemed to constitute maximum standards and procedures for purposes of limiting medical assistance reimbursement pursuant to the social services law. Such standards and procedures may thereafter be changed or added to by the council only upon the recommendation of the commissioner. For the purposes of ensuring that the health and safety of the residents of hospitals are not endangered, the council may promulgate changes in the minimum acceptable standards and procedures referred to herein upon recommendation of the commissioner, and

(vi) the establishment of a system of accounts and cost findings to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class in

accordance with sections twenty-eight hundred three-b and twenty-eight hundred five-a of this article.

(b) The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

3. The commissioner may enter into contracts with any political subdivision, voluntary non-profit agency or health systems agency and such entities are authorized to enter into contracts with the commissioner to effectuate the purposes of this article, however, contracts with voluntary non-profit agencies may not provide for payment for general hospital out-patient and emergency services or for treatment or diagnostic center services unless the commissioner is satisfied that the costs incurred for such services are approvable pursuant to the provisions of section twenty-eight hundred seven of this article.

4. At the request of the commissioner, hospitals shall furnish to the department such reports and information as it may require to effectuate the provisions of this article.

5. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this article or the determinations, rules, regulations and orders of the commissioner or the council.

6. The council, by a majority vote of its members and subject to the approval of the commissioner, shall adopt rules and regulations to establish (a) a system of penalties of up to one thousand dollars per day for continuing violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter and pertaining to patient care by residential health care facilities, specifying the violations and the amount of the penalty to be assessed in connection with each such violation, and (b) a system by which the rate of payment approved for a residential health care facility pursuant to section twenty-eight hundred seven of this chapter and certified to the department of social services for purposes of reimbursement in the medical assistance program, is reduced in sufficient amount to collect such penalties. Any reduction of rate to collect penalties shall be

limited to five percent of the otherwise established per diem rate or that portion of the per diem rate which represents the owner's return on equity, as defined by regulation, whichever is less.

7. The commissioner shall have the power to assess penalties in accordance with the system of penalties adopted pursuant to subdivision six of this section and pursuant to a hearing conducted in accordance with section twelve-a of this chapter. No penalty shall be assessed pursuant to subdivision six of this section unless the facility has received at least thirty days written notice of the existence of the violation, the amount of the penalty for which it may become liable and the steps which must be taken to rectify the violation. If the facility fails to rectify the violation within said thirty day period, it shall thereafter be liable for such penalty. Any such penalties shall be subject to release and compromise by the commissioner in the same manner as a penalty provided by subdivision one of section twelve of this chapter. Any penalty assessed pursuant to subdivision six of this section shall be subject to recovery in the same manner as a penalty provided by subdivision one of section twelve of this chapter or pursuant to the system for reduction of the rate of payment to the facility adopted pursuant to clause (b) of subdivision six of this section. Any such penalty assessed pursuant to subdivision six of this section shall be additional and cumulative to all other penalties or remedies existing for violations of rules and regulations promulgated pursuant to article twenty-eight of this chapter. The provisions of this subdivision shall not be applicable to nor limit any power to assess penalties pursuant to section twelve of this chapter; provided, however, that if a penalty is assessed for a violation pursuant to this subdivision, no penalty shall be assessed for such violation pursuant to section twelve of this chapter, and if a penalty is assessed for a violation pursuant to section twelve of this chapter, no penalty shall be assessed for such violation pursuant to this subdivision.

8. (a) Notwithstanding any inconsistent provision of law, the commissioner shall establish procedures to be followed by hospitals for notification to mothers and reporting under section three hundred sixty-six-g of the social services law.

(b) Notwithstanding any inconsistent provision of section twelve of this chapter or any other law, the commissioner may impose a civil penalty of up to three thousand five hundred dollars for each violation of the requirements of subdivision one of section three hundred sixty-six-g of the social services law or the rules and regulations promulgated pursuant to such section, pertaining to reporting to the department, or such other entity designated by the department, of each live birth to a woman receiving medical assistance. Any such civil penalties shall be assessed subject to the applicable provisions of sections twelve and twelve-a of this chapter.

8-a. Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall develop a program to facilitate the use of a triage system of care in emergency rooms of hospitals that are subject to the provisions of this article. In developing such program the commissioner shall consider the manner in which such a system would be coordinated, how such a system would provide greater efficiency, provide cost savings to public health programs and a higher quality of care. Within one year from the enactment of such program, the commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly regarding: the impact of such a system on the cost of Medicaid covered services in the hospital setting; quality of care in facilities; along with any other data as may be appropriate.

9. (a) General hospitals shall, no later than April first, two thousand, submit to the commissioner a plan for compliance with part four hundred five of the official compilation of codes, rules and regulations of the state of New York regarding the working conditions of and limits on working hours for certain members of a hospital's medical staff and postgraduate trainees in such form and manner as specified by the commissioner.

(b) The commissioner shall audit each hospital for compliance with its plan and the applicable regulation on an annual basis. Based upon an initial written audit finding of noncompliance the commissioner shall assess a civil penalty of six thousand dollars for each instance of noncompliance identified in such initial audit.

(c) Within thirty days after the hospital's receipt of written notice of noncompliance the hospital shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall audit each such hospital for compliance with its plan and the applicable regulations within a reasonable time after submission of such plan of correction. Upon a written finding by the commissioner within one hundred eighty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of twenty-five thousand dollars. Upon a further subsequent written finding by the commissioner within one hundred eighty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of fifty thousand dollars. Upon each and every subsequent written finding by the commissioner within three hundred sixty days of the initial audit finding of noncompliance that the hospital has failed to substantially adhere to its plan of correction the commissioner shall assess the hospital a civil penalty of fifty thousand dollars.

(d) The penalties assessed pursuant to paragraph (c) of this subdivision shall be subject to the provisions of section twelve-a of this chapter.

(e) Hospitals shall submit to the commissioner any data necessary to perform audits pursuant to this subdivision. Any hospital which fails to produce data or documentation requested in furtherance of such audit within thirty days of such request may be assessed by the commissioner a civil penalty of ten thousand dollars.

10. (a) All civil penalties assessed and collected pursuant to section twelve of this chapter for violations of this article and regulations promulgated thereunder related to the operation of residential health care facilities, and all civil monetary penalties related to the operation of nursing facilities received from the federal government in accordance with subdivision (h) of section nineteen hundred nineteen of the federal social security act, shall be deposited by the commissioner and credited to the quality of care improvement account which shall be

established by the comptroller in the special revenue fund-other. To the extent of funds appropriated therefor, funds shall be made available to the department for expenditures related to the protection of the health or property of residents of residential health care facilities that are found to be deficient.

(b) Any funds available pursuant to paragraph (a) of this subdivision, not used for the purposes of paragraph (a) of this subdivision, shall be used, at the commissioner's discretion, to support activities and initiatives intended to improve resident quality of care at residential health care facilities found to be deficient, as well as for such other purposes as are described in this paragraph. Such activities may include, but are not limited to, relocation of residents to other facilities and the maintenance and operation of a facility pending correction of deficiencies or closure. The commissioner may also make grants to residential health care facilities that support facilities' activities and initiatives intended to improve residential quality of care pursuant to a request for proposals process.

* 11. (a) The commissioner shall make regulations relating to midwifery birth centers, including relating to establishment, construction, and operation, considering the standards of state and national professional associations of midwifery birth centers, in consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services.

(b) (i) As used in this subdivision, "accrediting organization" means a national accrediting organization that provides accreditation to midwifery birth centers, recognized by the commissioner in consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services. The commissioner shall not unreasonably withhold recognition of an organization seeking to be recognized under this paragraph.

(ii) Where a proposed midwifery birth center demonstrates the intent and capability to obtain and maintain accreditation by an accrediting organization, and fully completes and files an application with the public health and health planning council on forms provided by the department, it shall be deemed upon approval of the public health and health planning council to meet the requirements of this article for a midwifery birth center for approval of a certificate of incorporation,

articles of organization and establishment, contingent on obtaining and maintaining that accreditation. Notwithstanding any other provision of this article to the contrary, such application to the public health and health planning council shall include information to: (A) satisfy the character and competence criteria found in subdivision three of section twenty-eight hundred one-a of this article; (B) demonstrate that the legal structure of the proposed operator of the midwifery birth center complies with the requirements for establishment of hospitals under section twenty-eight hundred one-a of this article; (C) evidence the capability to fund any acquisition, renovations, and construction costs; and (D) demonstrate that the premises and equipment comply with required life safety and building standards necessary to protect the life, safety and welfare of patients and staff. Upon receipt of a completed application, the department shall schedule such application for consideration at the next available and appropriate committee meeting by the public health and health planning council. If the department receives an incomplete application, the department shall communicate with the applicant until such time as the application is completed and filed with the public health and health planning council for its approval or disapproval, or the applicant withdraws the application.

(iii) Regulations and requirements of the commissioner under paragraph (a) of this subdivision for approval of a certificate of incorporation, articles of organization, establishment, and operation of a midwifery birth center established or seeking to be established under this article, including a determination of public need and compliance with operational and physical plant standards, shall not be inconsistent with: (A) article one hundred forty of the education law; (B) the standards of the accrediting organization from which the midwifery birth center proposes to seek, seeks or has obtained accreditation; (C) life safety code or other building standards the commissioner deems necessary to protect the life, safety and welfare of patients and staff; and (D) subparagraph (ii) of this paragraph. Regulations, requirements and guidance under this subparagraph shall be made by the commissioner after consultation with representatives of midwives, midwifery birth centers, and general hospitals providing obstetric services. To the extent any of the standards in this subparagraph conflict, the commissioner shall accommodate or modify the application of any standard to harmonize and

maximize the intent of the standards.

* NB There are 2 sb 11's

* 11. Notwithstanding any provision of this article, or any rule or regulation under this article to the contrary, the commissioner shall allow outpatient clinics of general hospitals and diagnostic and treatment centers to provide off-site primary care services that are:

(a) primary care services ordinarily provided to patients on-site at the outpatient clinic or diagnostic and treatment center and are not home care services defined in subdivision one of section thirty-six hundred two of this chapter or the professional services enumerated in subdivision two of such section;

(b) provided by a primary care professional to a patient with a pre-existing clinical relationship with the outpatient clinic or diagnosis and treatment center, or with the health care professional providing the service; and

(c) provided to a patient who is unable to leave his or her residence to receive services at the outpatient clinic or diagnostic and treatment center without unreasonable difficulty due to circumstances, including but not limited to, clinical impairment.

Nothing in this subdivision shall preclude a federally qualified health center from providing off-site services in accordance with department regulations.

* NB There are 2 sb 11's

12. (a) Each residential health care facility shall, no later than ninety days after the effective date of this subdivision and annually thereafter, or more frequently as may be directed by the commissioner, prepare and make available to the public on the facility's website, and immediately upon request, in a form acceptable to the commissioner, a pandemic emergency plan which shall include but not be limited to:

(i) a communication plan:

(A) to update authorized family members and resident representatives of infected residents at least once per day and upon a change in a resident's condition and at least once a week to update all residents and authorized families and resident representatives on the number of infections and deaths at the facility, and to update all residents,

authorized family members, and resident representatives at the facility not later than five o'clock p.m. the next calendar day following the detection of a confirmed infection of a resident or staff member, or at such earlier time as guidance from the federal centers for Medicaid and medicare services or centers for disease control and prevention may provide, by electronic or such other means as may be selected by each resident, authorized family member or resident representative; and

(B) that includes a method to provide all residents with daily access, at no cost, to remote videoconference or equivalent communication methods with family members and guardians; and

(C) that includes a method, consistent with any guidance and regulations issued by the commissioner, to provide all residents with access, at no cost, to state long-term care ombudsman program staff and volunteers, and that provides state long-term care ombudsman program staff and volunteers with access to the facility; and

(ii) protection plans against infection for staff, residents and families, including:

(A) a plan for hospitalized residents to be readmitted to such residential health care facility after treatment, in accordance with all applicable laws and regulations; and

(B) a plan for such residential health care facility to maintain or contract to have at least a two-month supply of personal protective equipment; and

(C) a plan or procedure, consistent with any guidance issued by the federal centers for Medicaid and medicare services or centers for disease control and prevention, for placement or grouping of residents within a facility to reduce transmission of the pandemic disease during an infectious disease outbreak in the residential health care facility; and

(iii) a plan for preserving a resident's place in a residential health care facility if such resident is hospitalized, in accordance with all applicable laws and regulations.

(b) The residential health care facility shall prepare and comply with the pandemic emergency plan. Failure to do so shall be a violation of this subdivision and may be subject to civil penalties pursuant to section twelve and twelve-b of this chapter. The commissioner shall review each residential health care facility for compliance with its

plan and the applicable regulations in accordance with paragraphs (a) and (b) of subdivision one of this section.

(c) Within thirty days after the residential health care facility's receipt of written notice of noncompliance such residential health care facility shall submit a plan of correction in such form and manner as specified by the commissioner for achieving compliance with its plan and with the applicable regulations. The commissioner shall ensure each such residential health care facility complies with its plan of correction and the applicable regulations.

(d) The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this subdivision.

13. The commissioner shall require each residential health care facility to provide residents and their families with a separate document, as part of an intake application, in no less than twelve-point font, that includes information on how a potential resident and their family members can look up complaints, citations, inspections, enforcement actions, and penalties taken against the facility including the web address for the New York state nursing home profiles website that is maintained by the department and the nursing home compare website maintained by the United States department of health and human services, if applicable.

14. (a) The commissioner, in consultation with the state long-term care ombudsman, shall establish policies and procedures for: (i) reporting to the department, by staff and volunteers of the long-term care ombudsman program, on issues identified or witnessed by such staff and volunteers that relate to actions, inactions or decisions that may adversely affect the health, safety and welfare of residents at residential health care facilities licensed or certified by the department in this state. Such policies and procedures shall include, but not be limited to, establishing a telephone hotline number and reporting form on the department's website for use by long-term care ombudsman program staff and volunteers for the submission of reports;

(ii) timely and regular resolution to any such issues reported to the department pursuant to subparagraph (i) of this paragraph. No later than sixty days after the receipt of any such issue, the department shall

provide the state long-term care ombudsman a report on the status of such issue. Following the initial report, the department shall provide additional reports to the state long-term care ombudsman no less than every ninety days thereafter until such issue is resolved. Upon resolution of such issue, the department shall provide a timely report to the state long-term care ombudsman indicating the manner in which the issue was resolved; and

(iii) requiring the department to notify the local ombudsman entity as defined in paragraph (c) of subdivision one of section two hundred eighteen of the elder law after the department conducts a recertification survey of a facility.

(b) Nothing in this subdivision shall be construed to limit in any way a resident's right to privacy and confidentiality pursuant to the regulations of the long-term care ombudsman program or the right to refuse to consent to the involvement of the long-term care ombudsman.

(c) As used in this subdivision: (i) "resolution" shall mean closure of a complaint by the department, whether closed as substantiated or unsubstantiated; and (ii) "status" shall mean whether the complaint has been assigned to department staff for investigation, whether the complaint remains open under active investigation, or whether the complaint has reached resolution.

§ 2803-a. Authority to contract. Hospitals, including hospitals described in subdivision ten of section 1.03 of the mental hygiene law, are hereby authorized, under such rules and regulations as the council may authorize, to enter into contracts and make arrangements among themselves and among other municipal, state, federal or privately owned hospitals, or any medical schools, or other health related facilities having or utilizing hospital services or facilities or voluntary ambulance services registered or certified pursuant to article thirty of the public health law or nutrition programs that receive federal, state or local government funding, whether or not located in this state or elsewhere, for the

1. mutual use, or exchange of medical resources including, but not limited to, real or personal property or employment of personnel;

2. joint purchases of goods, supplies and services; or

3. development of medical information, techniques and facilities useful in the progress of the medical art; reduction of medical costs and promotion of a more efficient and effective approach to the delivery of health care services.

Any contract between any such hospitals and such voluntary ambulance services shall be limited to joint purchases of goods and supplies necessary for the support of such ambulance services or otherwise used by such hospitals.

*** § 2803-aa. Sick cell disease information distribution.** The commissioner shall design an informational packet about sick cell disease, including screening, prevention, and treatment information. Every general hospital shall distribute the packet to every patient, or, if the patient lacks capacity to make health care decisions, to a person who has authority to make health care decisions for the patient, who is suspected to be at high risk of inheriting sick cell disease.

* NB There are 2 § 2803-aa's

*** § 2803-aa. Nursing home infection control competency audit.** 1. The commissioner shall establish in the department a program for audits of nursing homes to measure specific core competencies relating to infection control of each nursing home. The audits shall commence on December 1, 2022, and shall be conducted annually thereafter.

2. (a) The audit shall utilize a checklist that is consistent with focused infection control survey standards issued by the federal centers for Medicare and Medicaid services to evaluate infection control competency of each nursing home.

(b) A nursing home must meet all metrics on the checklist developed pursuant to paragraph (a) of this subdivision to be scored as in compliance with infection control.

(c) If a nursing home fails to meet all metrics on the checklist developed pursuant to paragraph (a) of this subdivision, the department shall conduct another infection control audit within ninety days of the initial determination. The department shall continue to conduct such ninety day audits until the nursing home is scored as in compliance with infection control competency. The department may also pursue administrative penalties, including but not limited to citation for violation of infection control standards and imposing civil monetary penalties pursuant to section twelve of this chapter.

3. An audit of core competencies shall include, but not be limited to, the following, and shall be consistent with focused infection control survey standards issued by the federal centers for Medicare and Medicaid services:

(a) Infection control. (i) The nursing home shall assign an infection lead staff person to implement infection control based on federal and state public health advisories, guidelines and rules.

(ii) The nursing home shall have a written infection control program which includes, but is not limited to:

(A) A plan to investigate, control and take action to prevent infections in the nursing home;

(B) Procedures for isolation and universal precautions for residents suspected or confirmed to have a contagious or infectious disease; and

(C) A record of incidences and corrective actions related to infections at the nursing home.

(iii) During an officially declared national emergency, or state or municipal emergency declared pursuant to article two-B of the executive law, related to a contagious or infectious disease outbreak, the nursing home shall have screening requirements for every individual entering the facility, including staff, for symptoms associated with the infectious disease outbreak.

(iv) The nursing home shall have a staffing and cohorting plan to limit transmission, which is based on national (for example, centers of disease control and centers for Medicare and Medicaid services), state or local public health authority recommendations. Such staffing and cohorting plan may include, but not be limited to:

(A) Having dedicated, consistent staffing teams who directly interact

with residents that are confirmed or suspected to be infected with a contagious or infectious disease;

(B) Limiting clinical and other staff who have direct resident contact to specific areas of the facility and not rotating staff between various areas of the facility during the period they are working each day during periods of recognized outbreaks; and

(C) Having a dedicated space in the facility for cohorting and managing care for residents with an infectious disease, such as COVID-19.

(v) The nursing home shall ensure ongoing access to the necessary supplies for hand hygiene for staff and residents, hospital disinfectants or alternatives to allow for necessary and appropriate cleaning and disinfecting of surfaces and shared resident care equipment.

(vi) The nursing home shall train staff and establish protocols for selecting, donning and doffing appropriate personal protective equipment and demonstrate competency during resident care. The nursing home must keep a record of staff training in proper storage, use, reuse, and disposal of personal protective equipment.

(vii) The nursing home must designate a staff member or members who is responsible for ensuring the proper use of personal protective equipment by all staff.

(b) The nursing home shall demonstrate that there has been advanced planning, in alignment with the facility's emergency preparedness plans and pandemic emergency plan, for contingent staffing needs in the case of staff quarantines that shall have an employee responsible for conducting a daily assessment of staffing status and needs during an outbreak of infectious or contagious diseases, and institute a sick-leave policy that does not punish staff with disciplinary action if they are absent from work because they are exhibiting symptoms, or test positive, for an infectious disease. Such policies shall offer the maximum amount of flexibility to staff and be consistent with state guidance.

(c) The nursing home shall have a written plan for daily communications with staff, residents, and the residents' families regarding the status of infections at the nursing home. Such plan shall be consistent with the requirements set forth in paragraph (a) of

subdivision twelve of section twenty-eight hundred three of this article. The nursing home must designate one or more staff members who are responsible for these communications with staff, residents and residents' families.

* NB There are 2 § 2803-aa's

§ 2803-b. Uniform reports and accounting systems for hospital costs.

1. The council, after public hearings with respect to its proposed systems of uniform hospital accounting and reporting, shall, by majority vote of its members and subject to approval of the commissioner, adopt and amend approved systems of uniform hospital accounting and reporting which are designed to enable hospitals to fairly, accurately and efficiently prepare the financial reports required by subdivision three of this section. Existing systems of accounting and reporting used by hospitals shall be examined and taken into consideration by the council in carrying out its function pursuant to this section. The council shall take such steps as are necessary to adopt the approved system of uniform hospital accounting and reporting by January first, nineteen hundred seventy-five.

2. The council, where appropriate to reflect differences in hospital size and services or in the method of providing or paying for hospital and related services, may allow for modifications in the accounting systems approved pursuant to subdivision one of this section.

3. Every organization which operates, conducts or maintains a hospital, and the officers thereof, shall furnish to the department with respect to each licensed hospital operated, conducted or maintained by the organization, within one hundred twenty days after the close of each fiscal year commencing after the adoption of systems of uniform hospital accounting and reporting approved under subdivision one of this section, all of the following reports on forms specified by the council:

(a) A balance sheet detailing the assets, liabilities and net worth of the hospital at the end of its fiscal year;

(b) A statement of income, expenses, and operating surplus or deficit for the annual period ending on the balance sheet date;

(c) A statement detailing the source of application of all funds expended by the hospital for the period encompassed by the income statement required by paragraph (b) of this subdivision;

(d) A report of hospital expenditures which allocates the costs of nonrevenue-producing departments of a hospital to the other nonrevenue-and revenue-producing centers which they serve. This report shall be accompanied by a sufficiently detailed statistical report containing data describing the hospital's basic services and patient statistics which identifies costs related to categories of hospital services delivered to patients by each department of the hospital, in accordance with a list of such services required by the council pursuant to subdivision one of this section.

4. The commissioner shall adopt forms of authentication for use by hospital officers or licensed accountants preparing reports under this section stating that each such officer or accountant making the authentication believes that to the extent of his knowledge and information each statement in the report is true.

§ 2803-bb. Provision of language assistance. Every general hospital shall develop a language assistance program to ensure meaningful access to the general hospital's services and reasonable accommodation for all patients who require language assistance. Program requirements shall include:

1. the designation of a language assistance coordinator who shall report to general hospital administration and who shall provide oversight for the provision of language assistance services;

2. policies and procedures that ensure timely identification and ongoing access for patients in need of language assistance services;

3. the development of materials that will be made available for patients and potential patients that summarize the process and method to access free language assistance services;

4. ongoing education and training for administrative, clinical and other employees with direct patient care contact regarding the importance of culturally and linguistically competent service delivery and how to access the general hospital's language assistance services on behalf of patients;

5. signage, as designated by the department, regarding the availability of free language assistance services in public entry locations and other public locations;

6. identification of language of preference and language needs of each patient upon initial visit to the general hospital;

7. documentation in the medical record of the patient's language of preference, language needs, and the acceptance or refusal of language assistance services;

8. a provision that family members, friends, or non-general hospital personnel shall not act as interpreters, unless:

(a) the patient agrees to their use;

(b) free interpreter services have been offered by the general hospital and refused; and

(c) issues of age, competency, confidentiality, or conflicts of interest are taken into account. Any individual acting as an interpreter should be sixteen years of age or older; individuals younger than sixteen years of age shall only be used in emergency circumstances and their use documented in the medical record;

9. management of a resource of skilled interpreters and persons skilled in communicating with vision and/or hearing-impaired individuals. Interpreters and persons skilled in communicating with vision and/or hearing-impaired individuals shall be available to patients within a reasonable period of time from a request to general hospital administration by the patient, the patient's family or representative or the provider of medical care. The commissioner may approve reasonable time periods to the provisions of this subdivision regarding interpreters and persons skilled in communicating with vision

and/or hearing-impaired individuals for patients of rural general hospitals which:

(a) demonstrate that they have taken and are continuing to take all reasonable steps to fulfill these requirements but are not able to fulfill such requirements immediately for reasons beyond the general hospital's control; and

(b) have developed and implemented effective interim plans addressing the communications needs of individuals in the general hospital service area;

10. an annual needs assessment utilizing demographic information available from the United States bureau of the census, general hospital administrative data, school system data, or other sources, that shall identify limited English-speaking groups comprising more than one percent of the total general hospital service area population. Translations/transcriptions of significant general hospital forms and instructions shall be regularly available for the languages identified by the needs assessment; and

11. reasonable accommodation for a family member or patient's representative to be present to assist with the communication assistance needs for patients with mental and developmental disabilities.

§ 2803-c. Rights of patients in certain medical facilities. 1. The principles enunciated in subdivision three hereof are declared to be the public policy of the state and a copy of such statement of rights and responsibilities shall be posted conspicuously in a public place in each facility covered hereunder.

2. The commissioner shall require that every nursing home and facility providing health related service, as defined in subdivision two and paragraph (b) of subdivision four of section twenty-eight hundred one of this article, shall adopt and make public a statement of the rights and responsibilities of the patients who are receiving care in such facilities, and shall treat such patients in accordance with the provisions of such statement.

3. Said statement of rights and responsibilities shall include, but not be limited to the following:

a. Every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the facility shall encourage and assist in the fullest possible exercise of these rights.

b. Every patient shall have the right to have private communications and consultations with his or her physician, attorney, and any other person.

c. Every patient shall have the right to present grievances on behalf of himself or herself or others, to the facility's staff or administrator, to governmental officials, or to any other person without fear of reprisal, and to join with other patients or individuals within or outside of the facility to work for improvements in patient care.

d. Every patient shall have the right to manage his or her own financial affairs, or to have at least a quarterly accounting of any personal financial transactions undertaken in his or her behalf by the facility during any period of time the patient has delegated such responsibilities to the facility.

e. Every patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions.

f. Every patient shall have the right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing personal possessions.

g. Every patient shall have the right to receive courteous, fair, and

respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis.

h. Every patient shall be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency in which case the restraint may only be applied by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and in the case of use of a chemical restraint a physician shall be consulted within twenty-four hours.

i. A statement of the facility's regulations and an explanation of the patient's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of the other patients.

j. A statement that should the patient be adjudicated incompetent and not be restored to legal capacity, or if a conservator should be appointed for the patient, the above rights and responsibilities shall be exercised by the appointed committee or conservator in a representative capacity.

k. Every patient shall have the right to receive upon request kosher food or food products prepared in accordance with sections two hundred one-a, two hundred one-b and two hundred one-c of the agriculture and markets law.

k-1. Every patient shall have the right to receive upon request halal food or food products prepared in accordance with sections two hundred one-e, two hundred one-f and two hundred one-g of the agriculture and markets law.

l. Pursuant to regulations promulgated by the commissioner, no facility or individual and no general hospital providing medical care to persons having been admitted from such facilities or from adult care

facilities covered by the provisions of section four hundred sixty-one-b of the social services law, or to applicants for readmission to such facilities or to adult care facilities covered by the provisions of section four hundred sixty-one-b of the social services law, shall restrict or prohibit the access to the facility or general hospital nor interfere with the performance of the official duties, including confidential visits with residents, of duly designated persons participating in the long term care ombudsman program as provided for in section two hundred eighteen of the elder law.

m. Pursuant to regulations promulgated by the commissioner in consultation with the director of the office for the aging, no facility shall restrict or prohibit access by records access ombudsmen specially designated under section five hundred forty-four of the executive law to the medical or personal records of any patient or resident if such patient or resident, or, where appropriate, committee for an incompetent, has given express written consent to such disclosure; provided, however, that (i) in the case of medical records, disclosure may be exclusive of the personal notes of the physician as defined in such regulations and (ii) access may be limited to such times as may be specified in such regulations. Such records shall be made available by a member or members of the facility's staff who shall be designated by the facility to provide access to and, where necessary, interpretation of such records to such records access ombudsman, who shall have the right to photocopy such records. The facility may charge a reasonable fee for photocopying pursuant to such regulations. Disclosure to a records access ombudsman of records of any patient or resident pursuant to the written consent of such patient or resident shall not give rise to any claim against the facility, its staff, or the patient's or resident's physician based solely on the fact of such disclosure pursuant to such written consent. Nothing in this paragraph shall be construed to limit or abridge any right of access to records, including financial records, otherwise available to ombudsmen, patients or residents, or any other person.

n. Pursuant to regulations promulgated by the commissioner in consultation with the director of the office for the aging, no facility

or individual shall retaliate or take reprisals against any resident, employee, or other person for having filed a complaint with, or having provided information to, any long term care patient ombudsman functioning in accordance with section five hundred forty-four or five hundred forty-five of the executive law, nor shall any facility or individual interfere with the official duties of any such ombudsman. Such regulations shall provide for appropriate sanctions with respect to such retaliation, reprisals, or interference.

(o) Every patient shall have the right to authorize those family members and other adults who will be given priority to visit consistent with the patient's or resident's ability to receive visitors.

p. A statement informing the patient of his or her right to make organ, tissue or whole body donations, and the means by which the patient may make such a donation. The commissioner shall promulgate any rules and regulations necessary to implement the provisions of this paragraph.

q. A statement indicating the policy of the facility regarding the granting of physician privileges to residents.

r. Every patient shall have the right to remain in care unless the patient is appropriately discharged or transferred in accordance with section two thousand eight hundred three-z of this article and a residential health care facility shall not attempt to compel or retaliate against an individual that chooses to remain in care.

4. Each facility shall give a copy of the statement to each patient at or prior to the time of admission to the facility, or to the appointed personal representative at the time of appointment and to each member of the facility's staff.

5. Each facility shall prepare a written plan and provide appropriate staff training to implement each patient's right included in the statement.

6. The department shall translate and make available to all facilities

the statement in the ten most common non-English languages spoken by individuals with limited-English proficiency in New York state as based on the most recent United States census. Each facility shall post and make available copies of said statement for residents under subdivisions one, two, and four of this section.

§ 2803-c-1. Rights of patients in certain medical facilities; long-term care ombudsman program. 1. Each nursing home and residential health care facility providing health related service, as defined in subdivisions two and three and paragraph (b) of subdivision four of section twenty-eight hundred one of this article, shall post in a conspicuous place or places where notices to residents are customarily posted, and shall provide each member of the facility's staff, and each patient and their appointed personal representative at or prior to the time of admission to the facility, or at the time of the representative's appointment, the following contact information:

(a) contact information for the state and relevant regional office of the long-term care ombudsman program as provided for in section two hundred eighteen of the elder law; and

(b) contact information for the department's nursing home complaint hotline.

2. Nursing homes and residential health care facilities shall provide updated contact information for the state and relevant regional offices of the long-term care ombudsman program to all residents and their appointed personal representatives twice a year.

§ 2803-c-2. Lesbian, gay, bisexual and transgender, and people living with HIV long-term care facility residents' bill of rights. 1.

Definitions. For the purposes of this section:

(a) "Gender identity or expression" shall have the same meaning as defined by section two hundred ninety-two of the executive law.

(b) "Long-term care facilities" or "facilities" shall mean residential health care facilities as defined in subdivision three of section twenty-eight hundred one of this article, adult care facilities as

defined in subdivision twenty-one of section two of the social services law, and assisted living residences, as defined in article forty-six-B of this chapter, or any facilities which hold themselves out or advertise themselves as providing assisted living services and which are required to be licensed or certified under the social services law or this chapter.

(c) "Long-term care facility staff" or "facility staff" shall mean all individuals employed by or contracted directly with the facility.

(d) "Resident" shall mean a resident or patient of a long-term care facility.

2. (a) Except as provided in subdivision three of this section, it shall be unlawful for a long-term care facility or facility staff to discriminate against any resident on the basis of such resident's actual or perceived sexual orientation, gender identity or expression, or human immunodeficiency virus (HIV) status:

(i) deny admission to a long-term care facility, transfer or refuse to transfer a resident within a facility or to another facility, or discharge or evict a resident from a facility;

(ii) deny a request by residents to share a room;

(iii) where rooms are assigned by gender, assigning, reassigning or refusing to assign a room to a transgender resident other than in accordance with the transgender resident's gender identity, unless at the transgender resident's request;

(iv) prohibit a resident from using, or harass a resident who seeks to use or does use, a restroom available to other persons of the same gender identity, regardless of whether the resident has taken or is taking hormones, has had transition-related surgery, or is making a gender transition or appears to be gender-nonconforming. Harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity;

(v) willfully and repeatedly fail to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns, even if the resident is not present;

(vi) deny a resident the right to wear or be dressed in clothing, accessories, or cosmetics that are permitted for any other resident;

(vii) restrict a resident's right to associate with other residents or with visitors, including the right to consensual expression of intimacy or sexual relations, unless the restriction is uniformly applied to all residents in a nondiscriminatory manner; and

(viii) deny or restrict a resident from accessing appropriate medical or nonmedical care, or provide medical or nonmedical care, that unreasonably demeans the resident's dignity or causes avoidable discomfort.

(b) The provisions of this subdivision shall not apply to the extent that they are incompatible with any professionally reasonable clinical judgment that is based on articulable facts of clinical significance.

3. Each facility shall post the following notice alongside its current nondiscrimination policy in all places and on all materials where that policy is posted: "(NAME OF FACILITY) DOES NOT DISCRIMINATE AND DOES NOT PERMIT DISCRIMINATION, INCLUDING, BUT NOT LIMITED TO, BULLYING, ABUSE, HARASSMENT, OR DIFFERENTIAL TREATMENT ON THE BASIS OF ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS, OR BASED ON ASSOCIATION WITH ANOTHER INDIVIDUAL ON ACCOUNT OF THAT INDIVIDUAL'S ACTUAL OR PERCEIVED SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR HIV STATUS. YOU MAY FILE A COMPLAINT WITH THE OFFICE OF THE NEW YORK STATE LONG-TERM CARE OMBUDSMAN PROGRAM (PROVIDE CONTACT INFORMATION) IF YOU BELIEVE THAT YOU HAVE EXPERIENCED THIS KIND OF DISCRIMINATION."

4. (a) A facility shall employ procedures for recordkeeping, including, but not limited to, records generated at the time of admission, that include the gender identity, correct name, as indicated by the resident, and pronoun of each resident, as indicated by the resident and such records shall be kept up to date.

(b) The state long-term care ombudsman program shall establish policies and procedures for recording complaints filed from residents of long-term care facilities pursuant to this section.

5. Long-term care facilities shall protect personally identifiable information regarding residents' sexual orientation, whether a resident is transgender, a resident's transition history, and HIV status from

unauthorized disclosure, as required by the federal Health Insurance Portability and Accountability Act of 1996, if applicable, and any other applicable provision of federal or state law. A facility shall take any steps reasonably necessary to minimize the likelihood of inadvertent or incidental disclosure of that information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties.

6. Long-term care facility staff not directly involved in providing direct care to a resident, including, but not limited to, a transgender or gender-nonconforming resident, shall not be present during physical examination or the provision of personal care to such resident if such resident is partially or fully unclothed without the express permission of such resident, or such resident's legally authorized representative or responsible party. A facility shall use doors, curtains, screens, or other effective visual barriers to provide bodily privacy for all residents, including, but not limited to, transgender or gender-nonconforming residents, whenever they are partially or fully unclothed. In addition, all residents, including, but not limited to, lesbian, gay, bisexual, transgender or gender-nonconforming residents, shall be informed of and have the right to refuse to be examined, observed, or treated by any facility staff when the primary purpose is educational or informational rather than therapeutic, or for resident appraisal or reappraisal, and that refusal shall not diminish the resident's access to care for the primary purpose of diagnosis or treatment.

7. (a) At least once every two years, a long-term care facility shall ensure that every facility staff member who works directly with residents receives training on cultural competency focusing on residents who identify as lesbian, gay, bisexual or transgender and residents living with HIV. Such training shall be developed by the commissioner, in consultation with the director of the office for the aging and entities with expertise in the legal and social challenges faced by lesbian, gay, bisexual or transgender older adults and people living with HIV as they age and reside in long-term care facilities, and shall include, but not be limited to, providing facility staff with the

knowledge and skills necessary to provide effective care, in compliance with this section, for residents who identify as lesbian, gay, bisexual or transgender and residents living with HIV.

(b) Facility staff required to receive training under this subdivision shall receive the training within six months of hire unless the person provides proof of having received comparable training within the prior two years that the facility determines complies with this subdivision. If the facility accepts the person's proof of prior training, a record of the content of the prior training sufficient to determine its compliance with this subdivision shall be kept on site at the facility.

8. Nothing in this section should be construed to impede existing programs, benefits, or protections for lesbian, gay, bisexual or transgender residents or residents living with HIV at long-term care facilities.

§ 2803-d. Reporting abuses of persons receiving care or services in residential health care facilities. 1. The following persons are required to report in accordance with this section when they have reasonable cause to believe that a person receiving care or services in a residential health care facility has been abused, mistreated, neglected or subjected to the misappropriation of property by other than a person receiving care or services in the facility: any operator or employee of such facility, or employee of any corporation, partnership, organization or other entity which, and any other person who, is under contract with such facility, and any nursing home administrator, physician, medical examiner, coroner, physician's associate, specialist's assistant, osteopath, chiropractor, physical therapist, occupational therapist, registered professional nurse, licensed practical nurse, dentist, podiatrist, optometrist, pharmacist, psychologist, licensed master social worker, licensed clinical social worker, speech pathologist and audiologist.

2. In addition to those persons required to report suspected abuse, mistreatment, neglect or misappropriation of the property of persons receiving care or services in residential health care facilities, any

other person may make such a report if he or she has reasonable cause to believe that a person receiving care or services has been abused, mistreated, neglected or subjected to the misappropriation of property in the facility.

3. Reports of suspected abuse, mistreatment, neglect or the misappropriation of property made pursuant to this section shall be made immediately by telephone and in writing within forty-eight hours to the department. The department shall provide forms, which shall be available to be downloaded from the department's website, which may be, but are not required to be, used for making the written reports. Written reports shall include the following information: the identity of the person making the report and where he can be found; the name and address of the residential health care facility; the names of the operator and administrator of the facility, if known; the name of the subject of the alleged abuse, mistreatment, neglect or misappropriation of property, if known; the nature and extent of the abuse, mistreatment, neglect or misappropriation of property; the date, time and specific location of the occurrence; the names of next of kin or sponsors of the subject of the alleged abuse, mistreatment, neglect or misappropriation of property, if known; and any other information which the person making the report believes would be helpful to further the purposes of this section. Such written reports shall be admissible in evidence, consistent with the provisions of paragraph (f) of subdivision six of this section, in any actions or proceedings relating to abuse, mistreatment, neglect or misappropriation of property of persons receiving care or services in residential health care facilities. Written reports made other than on forms supplied by the commissioner which contain the information required herein shall be treated as if made on such forms.

4. Any person who in good faith makes a report pursuant to this section shall have immunity from any liability, civil or criminal, for having made such a report. For the purpose of any proceeding, civil or criminal, the good faith of any person required to report instances of abuse, mistreatment, neglect or misappropriation of property of persons receiving care or services in residential health care facilities shall

be presumed.

5. Notwithstanding the provisions of section two hundred thirty of this chapter, any licensed person who commits an act of abuse, mistreatment, neglect or misappropriation of property of a person receiving care or services in a residential health care facility and any licensed person required by this section to report an instance of suspected abuse, mistreatment, neglect or misappropriation of property of a person receiving care or services in a residential health care facility who fails to do so shall be guilty of unprofessional conduct in the practice of his or her profession.

6. (a) Upon receipt of a report made pursuant to this section, the commissioner shall cause an investigation to be made of the allegations contained in the report. Notification of the receipt of a report shall be made immediately by the department to the appropriate district attorney if a prior request in writing has been made to the department by the district attorney. At any time, if the department determines that there is a reasonable belief that a reported allegation may constitute a crime under the laws of the state of New York or the United States, the department shall notify the appropriate law enforcement official or authority. Prior to the completion of the investigation by the department, reasonable effort shall be made to notify, personally or by certified mail, any person under investigation for having committed an act of abuse, mistreatment, neglect or misappropriation of property. The commissioner shall make a written determination, based on the findings of the investigation, of whether or not sufficient credible evidence exists to sustain the allegations contained in the report or would support a conclusion that a person not named in such report has committed an act of abuse, neglect, mistreatment or misappropriation of property. A copy of such written determination, together with a notice of the right to a hearing as provided in this subdivision, shall be sent by registered or certified mail to each person who the commissioner has determined has committed an act of abuse, neglect, mistreatment or misappropriation of property. A letter shall be sent to any other person alleged in such report to have committed such an act stating that a determination has been made that there is not sufficient evidence to

sustain the allegations relating to such person. A copy of each such determination and letter shall be sent to the facility in which the alleged incident occurred.

(b) The commissioner may make a written determination, based on the findings of the investigation, that sufficient credible evidence exists to support a conclusion that a person required by this section to report suspected abuse, mistreatment, neglect or misappropriation of property had reasonable cause to believe that such an incident occurred and failed to report such incident. A copy of such written determination, together with a notice of the right to a hearing as provided in this subdivision, shall be sent by registered or certified mail to each person who the commissioner has determined has failed to report as required by this section.

(c) All information relating to any allegation which the commissioner has determined would not be sustained shall be sealed one hundred twenty days following notification of such determination to the person who made the report pursuant to this section, unless a proceeding pertaining to such allegation is pending pursuant to article seventy-eight of the civil practice law and rules. Whenever information is sealed, the commissioner shall notify any official notified pursuant to paragraph (a) of this subdivision that the information has been sealed.

(d) At any time within thirty days of the receipt of a copy of a determination made pursuant to this section, a person named in such determination as having committed an act of abuse, neglect, mistreatment or misappropriation of property, or as having failed to report such an incident, may request in writing that the commissioner amend or seal the record of such report, to the extent such report applies to such person, or such written determination. If the commissioner does not comply with such request within thirty days, such person shall have the right to a fair hearing to determine whether the record of the report or the written determination should be amended or sealed on the grounds that the record is inaccurate or the determination is not supported by the evidence. The burden of proof in such hearing shall be on the department. Whenever information is sealed, the commissioner shall notify any official notified pursuant to paragraph (a) of this subdivision that the information has been sealed.

(e) Except as hereinafter provided, any report, record of the

investigation of such report and all other information related to such report shall be confidential and shall be exempt from disclosure under article six of the public officers law.

(f) Information relating to a report made pursuant to this section shall be disclosed under any of the following conditions:

(i) pursuant to article six of the public officers law after sealing or amendment, if any, is made in accordance with a hearing conducted pursuant to this section, or at least forty-five days after a written determination is made by the commissioner concerning such report, whichever is later; provided, however, that the identity of the person who made the report, the victim, or any other person named, except a person who the commissioner has determined committed an act of abuse, neglect, mistreatment or misappropriation of property, shall not be disclosed unless such person authorizes such disclosure;

(ii) as may be required by the penal law or any lawful order or warrant issued pursuant to the criminal procedure law; or

(iii) to a person who has requested a hearing pursuant to this section, information relating to the determination upon which the hearing is to be conducted; provided, however, that the identity of the person who made the report or any other person who provided information in an investigation of the report shall not be disclosed unless such person authorizes such disclosure.

(g) Where appropriate, the commissioner shall report instances of abuse, mistreatment, neglect or misappropriation of property or the failure to report as required by this section, to the appropriate committee on professional conduct for the professions enumerated in subdivision one of this section when a determination has been made after the commissioner has provided an opportunity to be heard. The commissioner shall report instances of abuse, mistreatment, neglect, misappropriation of property by a nurse aide or other unlicensed individual and any brief statement by the nurse aide or other unlicensed individual disputing the finding to the nursing home nurse aide registry established pursuant to section twenty-eight hundred three-j of this article when a determination has been made after the commissioner has provided an opportunity to be heard.

7. In addition to any other penalties prescribed by law, any person

who commits an act of abuse, neglect, mistreatment or misappropriation of property, or who fails to report such an act as provided in this section, shall be deemed to have violated this section and shall be liable for a penalty pursuant to section twelve of this chapter after an opportunity to be heard pursuant to this section.

8. No residential health care facility or officer or employee thereof shall discharge or in any manner discriminate or retaliate against any person in any residential health care facility, or any relative, or sponsor thereof, or against any employee of the facility, or against any other person because such person, relative, legal representative, sponsor or employee has made, or is about to make, a report pursuant to this section, or has testified, or is about to testify, in any proceeding relating to abuse, mistreatment, neglect or misappropriation of property of a person receiving care or services in a residential health care facility. The supreme court may grant injunctive relief to any person subject to such retaliation or discrimination. Any violation of this subdivision shall be punishable pursuant to section twelve of this chapter.

9. No later than March fifteenth of every year the commissioner shall prepare and transmit to the governor and the legislature a report on the incidents of abuse, mistreatment, neglect and misappropriation of property of persons receiving care or services in residential health care facilities. No individual identifying information concerning any individual subjected to abuse, mistreatment, neglect or misappropriation of property shall be disclosed in a report made pursuant to this subdivision, or in any other report, except information which would be available pursuant to article six of the public officers law as provided in this section. Nothing in this section shall be construed to prohibit the maintenance or disclosure of, or require the sealing of, statistical data which would not reveal the identity of any person.

10. An investigation shall be made of each incident reported pursuant to this section.

11. The commissioner shall adopt regulations necessary to implement

this section.

*** § 2803-e. Residential health care facilities; return and redistribution of unused medication.** 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, the commissioner is hereby authorized and directed to permit either a resident or consultant pharmacist in a residential health care facility to return to the pharmacy from which it was purchased any unused medication provided that such medication is sealed in unopened, individually packaged units and within the recommended period of shelf life, and provided that such medication is not a controlled substance as defined in section thirty-three hundred six of the public health law.

2. The pharmacy to which such medication as described in subdivision one of this section is returned shall be permitted to receive, restock and redistribute that medication.

3. The pharmacy to which such medication as described in subdivision one of this section is returned shall be required to reimburse or credit the purchaser of that medication for the unused medication that is restocked and redistributed. No pharmacy shall be required to accept any medication returned under subdivision one of this section.

4. Neither an individual patient or the state, if a patient is a recipient of a state funded program, shall be charged for unused medication which according to the provisions of this law is returned for reimbursement or credit.

* NB There are 2 § 2803-e's

*** § 2803-e. Reporting incidents of possible professional misconduct.** 1. (a) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of the occurrence of any of the following: the suspension, restriction, termination or curtailment of the training, employment, association or professional privileges or the denial of the certification of completion

of training of an individual licensed pursuant to the provisions of title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare.

(b) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of obtaining knowledge of any information which reasonably appears to show that a physician is guilty of professional misconduct as defined in section sixty-five hundred thirty or sixty-five hundred thirty-one of the education law. A violation of this paragraph shall not be subject to the provisions of section twelve-b of this chapter.

2. Reports of possible professional misconduct made pursuant to this section shall be made in writing to the education department with respect to all individuals licensed pursuant to title eight of the education law except that such reports shall be made to the department of health in the case of physicians, physician's assistants and specialist's assistants. Written reports shall include the following information:

- (a) name, address, profession and license number of the individual;
- (b) a description of the action taken by the hospital including the reason for the action and the date thereof, or the nature of the action or conduct which led to the resignation or withdrawal, and the date thereof, stated with sufficient specificity to allow a reasonable person to understand which of the reasons enumerated in subdivision one of this section led to the action of the hospital or the resignation or withdrawal of the individual, and, if the reason was an act or omission of the individual, the particular act or omission;
- (c) any criminal conviction of which the hospital has knowledge; and

(d) such other information as the education department or the department of health shall require.

3. (a) Any report or information furnished to the education department or department of health in accordance with the provisions of this section shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issued in a pending action or proceeding.

(b) Any person, facility or corporation which makes a report pursuant to this section in good faith and without malice shall have immunity from any liability, civil or criminal, for having made such a report. For the purpose of any proceeding, civil or criminal, the good faith of any person required to make a report shall be presumed.

* NB There are 2 § 2803-e's

§ 2803-f. Respite projects. Residential health care facilities shall be permitted, with the prior approval of the commissioner in consultation with the director of the state office for the aging, to participate in respite projects pursuant to section two hundred eight of the elder law. No person shall receive services providing respite in a residential health care facility unless such person is medically eligible for admission to such facility. Reimbursement for services in a residential health care facility shall be as provided in sections twenty-eight hundred seven and twenty-eight hundred eight of this article for skilled nursing facility services or health-related services. The commissioner, in consultation with the director of the state office for the aging, shall promulgate rules and regulations to implement the provisions of this section.

§ 2803-g. Board of visitors in county owned residential health care facility. 1. Each public residential health care facility owned by a county may have a board of visitors consisting of at least seven members. Members shall be appointed by the county executive of the county in which the facility is located where the county charter or, in

the absence of such, county law provides that members of county boards, commissions, authorities or agencies are to be appointed by such an officer. Such appointments shall be made with the approval of the local legislative body of that county. In those counties without a county executive, appointments shall be made by the legislative body of the county. A visitor may be removed by the county legislative body for cause after notice and an opportunity for hearing on the charges.

2. Unless provided otherwise by local law, each board shall elect annually one member to serve as president of the board and one member to serve as secretary.

3. Visitors shall not receive compensation but may be reimbursed for their actual expenses in connection with their service as visitors by the facility they serve.

4. The board of visitors shall hold no less than six regular meetings annually, but a greater number of regular meetings may be scheduled by the board. The conditions under which special meetings may be called shall be established by local law or in by-laws of the board. The board may require the head administrator of the facility to submit a report at each meeting. The board shall keep a record of its proceedings and activities. A member of a board of visitors who has failed to attend three consecutive meetings shall be considered to have vacated his office unless the board has adopted rules to the contrary.

5. Upon the request of the head administrator of the facility or upon the board's initiative, the board shall consult, advise and work with the director with respect to community relations, conditions at the facility, preliminary plans for construction and alterations and programs and activities of the facility.

6. The board or any member of the board may visit and inspect the facility at any time without prior notice and may report on conditions to the local legislative body or the county executive and the commissioner of the New York state department of health. In addition, the board shall insure that a member or a committee of members shall

inspect the facility once every three months without prior notice. A member of a board of visitors who has failed to visit and inspect the facility at least twice a year shall be considered to have vacated his office unless otherwise ordered by the board.

7. The board shall have the power to investigate all charges against the administrator of the facility, all cases of alleged patient abuse or mistreatment, and any other complaint filed against the facility. The board shall receive from the facility copies of all accident reports and any reports of abuse or neglect involving patients of the facility. The board or any member of the board shall have the right to examine any books or papers of the facility at anytime, except that access to patient medical records shall be with the written consent of the patient or his legal representative. Unless provided otherwise by local law, the board shall have the power, in accordance with the civil practice law and rules, to require the production of any books or papers deemed relevant to the investigation. The board or a member may include in the report of their investigation or separately at any time, any matter pertaining to the management and affairs of the facility and may make recommendations to the county executive, or in the absence of such, the county legislative body and to the commissioner.

8. Once each year, the board shall make an independent assessment of conditions at the facility and shall submit a report on the assessment and recommendations to the commissioner and to the county executive, or in the absence of such, the county legislative body.

9. The county executive or the local legislative body shall notify the board of visitors of a residential health care facility of the proposed appointment of a head administrator to such facility with a request that the board report an expression of its opinion of the appointment and, if it objects thereto, the reasons for such an objection.

10. The board may establish by-laws which shall be available for public inspection at the facility and the office of the county attorney.

11. Members of the board of visitors shall be considered officers of

the county by which they are compensated for purposes of section four hundred nine of the county law. The county legislative body shall establish a code of ethics for the members of such board, including but not limited to provisions on conflict of interest and course of conduct.

§ 2803-h. Health related facility; pet therapy programs.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the approval of the commissioner, every residential health care facility, as defined in section twenty-eight hundred one of this article, may, at the discretion of such facility, board animals in such facility where such boarding would, in the determination of the commissioner and such facility, tend to promote the general well-being of the residents of such facility. The commissioner shall adopt rules and regulations necessary to implement the provisions of this section.

§ 2803-i. General hospital inpatient discharge review program. 1. A general hospital inpatient discharge review program applicable to all patients other than beneficiaries of title XVIII of the federal social security act (medicare) shall be established in accordance with this section. No general hospital inpatient subject to the provisions of this section may be discharged on the basis that inpatient hospital service in a general hospital is no longer medically necessary and that an appropriate discharge plan has been established unless a written notice of such determinations and a copy of the discharge plan have been provided to the patient or the appointed personal representative of the patient. The patient or the appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the discharge plan and receive a copy of both signed documents. Every general hospital shall use a common notice developed and disseminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall indicate that the patient is to be discharged, shall state the reasons therefor and shall state that the patient may request a review of such determinations. The patient, or the appointed personal representative of the patient may request a review of

such determinations by the appropriate independent professional review agent (or "review agent") in accordance with subdivision four of this section. Notwithstanding that the patient discharge review process provided in accordance with federal law and regulation shall apply to beneficiaries of title XVIII of the federal social security act (medicare), a written copy of the discharge plan, and discharge notice shall be provided to the beneficiary or the appointed personal representative of the beneficiary. The beneficiary or the appointed personal representative of the beneficiary shall have the opportunity to sign the documents and receive a copy of the signed documents.

2. (a) For patients eligible for payments by state governmental agencies for general hospital inpatient services as the patient's primary payor, an independent professional review agent shall mean the commissioner or his designee. In conducting general hospital inpatient discharge reviews in accordance with this section, the commissioner may utilize the services of department personnel or other authorized representatives, including a review agent approved in accordance with paragraph (b) of this subdivision.

(b) For patients who are not beneficiaries of title XVIII of the federal social security act (medicare) nor eligible for payments by state governmental agencies as the patient's primary payor, an independent professional review agent shall mean a third party payor of hospital services or other corporation approved by the commissioner in writing for purposes of conducting general hospital inpatient discharge reviews in accordance with this section. For a third party payor of hospital services or other corporation to be approved as an independent professional review agent in accordance with this paragraph, such third party payor or other corporation must meet the following criteria: (i) the review agent shall employ or otherwise secure the services of adequate medical personnel qualified to determine the necessity of continued inpatient hospital services and the appropriateness of hospital discharge plans; (ii) the review agent shall demonstrate the ability to render review decisions in a timely manner as provided in this section; (iii) the review agent shall agree to provide ready access by the commissioner to all data, records and information it collects and maintains concerning its review activities under this section; (iv) the

review agent shall agree to provide to the commissioner such data, information and reports as the commissioner determines necessary to evaluate the review process provided pursuant to this section; (v) the review agent shall provide assurances that review personnel shall not have a conflict of interest in conducting a discharge review for a patient based on hospital or professional affiliation; and (vi) the review agent meets such other performance and efficiency criteria regarding the conduct of reviews pursuant to this section established by the commissioner. The commissioner may withdraw approval of an independent professional review agent where such review agent fails to continue to meet approval criteria established pursuant to this paragraph.

(c) (i) Each general hospital shall enter into contracts with one or more independent professional review agents approved by the commissioner in accordance with paragraph (b) of this subdivision for purposes of conducting general hospital inpatient discharge reviews in accordance with this section for patients, including uncompensated care patients, who are not beneficiaries of title XVIII of the federal social security act (medicare) nor eligible for payments by state governmental agencies as the patients' primary payor; provided, however, a payor of hospital service included in the payor categories specified in paragraph (a) of subdivision one of section twenty-eight hundred seven-c of this article, other than state governmental agencies, may designate the review agent for their subscribers or beneficiaries or enrolled members and shall reimburse such designated review agent for costs of the discharge review program.

(ii) Notwithstanding any inconsistent provision of law, general hospital contract costs incurred in accordance with subparagraph (i) of this paragraph may be included as an additional charge for general hospital inpatient services in determining patient charges for payors included in the payor categories specified in paragraph (c) of subdivision one of section twenty-eight hundred seven-c of this article, or as a charge in addition to rates of payment for general hospital inpatient services in determining payment due for payors included in the payor categories specified in paragraph (b) of subdivision one of section twenty-eight hundred seven-c of this article, or paragraph (a) of such subdivision one if a payor has not designated a review agent for

such payor's subscribers or beneficiaries or enrolled members, or paragraph (a) or (b) of subdivision two of section twenty-eight hundred seven-c of this article. Such additional charges shall not be subject to maximum charge or rate of payment ceilings determined in accordance with section twenty-eight hundred seven-c of this article for such payors.

3. (a) If a general hospital and the attending physician agree that inpatient hospital service in a general hospital is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the federal social security act (medicare), and an appropriate discharge plan has been established for such patient, at that time the hospital shall provide the patient or the appointed personal representative of the patient with a written discharge notice and a copy of the discharge plan, meeting the requirements of subdivision one of this section.

(b) If a general hospital has determined that inpatient hospital service in a general hospital is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the federal social security act (medicare), and an appropriate discharge plan has been established for such patient but the attending physician has not agreed with the hospital's determinations, the hospital may request by telephone a review of the validity of the hospital's determinations by the appropriate independent professional review agent. Such review agent shall conduct a review of the hospital's determinations and prior to the conclusion of the review shall provide an opportunity to the treating physician and an appropriate representative of the hospital to confer and provide information which may include the patient's clinical records if requested by the review agent. Such review agent shall notify the hospital of the results of its review not later than one working day after the date the review agent has received the request, the records required to conduct such review, and the date of such conferring and receipt of any additional information requested. The hospital shall provide notice to the attending physician of the results of the review. If the review agent concurs with the hospital's determinations, the hospital shall provide the patient or his appointed personal representative with a written notice of such determinations and notice that the patient shall be financially responsible for continued stay, and with a copy of the proposed discharge plan. The patient or the

appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the proposed discharge plan and receive a copy of both signed documents. Every general hospital shall use a common notice developed and disseminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall indicate the determinations made, shall state the reasons therefor and that the patient's attending physician has disagreed and shall state that the patient or the appointed personal representative of the patient may request a review of such determinations by the appropriate review agent.

4. A patient in a general hospital, or the appointed personal representative of the patient, who receives a written notice in accordance with paragraph (a) or (b) of subdivision three of this section, may request a review by the appropriate review agent of the determinations set forth in such notice related to medical necessity of continued inpatient hospital service, the appropriateness of the discharge plan and the availability of required continuing health care services.

(a) If a patient while still hospitalized or while no longer an inpatient, or the appointed personal representative of such patient, requests a review by the appropriate review agent, the hospital shall promptly provide to the review agent the records required to review the determinations. Such request for a patient no longer an inpatient shall take place no later than thirty days after receipt of a notice provided in accordance with subdivision three of this section or seven days after receipt of a complete bill for all inpatient services rendered, whichever is later. The review agent shall conduct a review of such determinations and shall provide the treating physician and an appropriate representative of the hospital with an opportunity to confer and provide information prior to the conclusion of the review. The review agent shall provide written notice to the patient, or the appointed personal representative of the patient, and the hospital of the results of the review within three working days of receipt of the requests for review and the records required to review the determinations. The hospital shall provide notice to the attending physician of the results of the review.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, if a patient while still an inpatient in the general hospital, or the appointed personal representative of the patient, requests a review by the appropriate review agent not later than noon of the first working day after the date the patient, or the appointed personal representative of the patient, receives the written notice, the hospital shall provide to the appropriate review agent the records required to review the determinations by the close of business of such working day. The appropriate review agent shall conduct a review of such determinations and provide written notice to the patient, or the appointed personal representative of the patient, and the hospital of the results of the review not later than one full working day after the date the review agent has received the request for review and such records. The hospital shall provide notice to the attending physician of the results of the review.

5. Notwithstanding any inconsistent provision of law, if the appropriate review agent, upon any review conducted pursuant to paragraph (b) of subdivision three or pursuant to subdivision four of this section does not concur in the determinations, continued stay in a general hospital shall be deemed necessary and appropriate for the patient for purposes of payment for such continued stay in accordance with section twenty-eight hundred seven-c of this article.

6. If a patient eligible for payment for inpatient hospital services under a case based payment per discharge determined in accordance with section twenty-eight hundred seven-c of this article, or the appointed personal representative of the patient, requests a review by the appropriate review agent in accordance with paragraph (b) of subdivision four of this section, the hospital may not demand or request any payment for additional inpatient hospital services provided to such patient subsequent to the proposed time of discharge and prior to noon of the day after the date the patient or the appointed personal representative of the patient receives notice of the results of the review by the review agent other than payment determined in accordance with section twenty-eight hundred seven-c of this article and deductibles, copayments, or other charges that would be authorized for a patient for

whom inpatient hospital services in a general hospital continue to be necessary and appropriate.

7. In any review conducted pursuant to paragraph (b) of subdivision three or pursuant to subdivision four of this section, the review agent shall solicit the views of the patient involved, or the appointed personal representative of the patient, and the attending physician.

8. Each patient, or the appointed personal representative of the patient, provided a notice by a general hospital in accordance with subdivision three of this section shall be provided at such time by the hospital with a notice, in a form developed in accordance with rules and regulations adopted by the council and approved by the commissioner, of such patient's right to request a discharge review in accordance with this section. The patient or the appointed personal representative of the patient shall have the opportunity to sign this form and receive a copy of the signed form.

9. Upon discharge of a blind or visually impaired patient, a hospital shall offer to provide the patient's discharge plan in a large print version or, at the patient's or patient's representative's request, as an audio recording, to be made available to such patient or such patient's representative on compact disc or other medium as the hospital may offer, or as an electronically transmitted digital file, in addition to a written copy of the discharge plan.

10. The council shall adopt rules and regulations, subject to the approval of the commissioner, necessary to implement this section.

*** § 2803-j. Information for maternity patients.** 1. The commissioner shall require that every hospital and birth center shall prepare in printed or photocopied form and distribute at the time of pre-booking directly to each prospective maternity patient and, upon request, to the general public an informational leaflet. Such leaflet shall be designed by the commissioner and shall contain brief definitions of maternity related procedures and practices as specified in subdivision two of this

section and such other material as deemed appropriate by the commissioner. Hospitals and birth centers may also elect to distribute additional explanatory material along with the maternity patients informational leaflet. The commissioner shall make the information contained in the leaflet available on the department's website and shall present all annual statistical information compiled pursuant to subdivision three of this section on the department's website for the most recent five years for which such data is available.

1-a. The informational leaflet shall also include an explanation of the special provisions relating to maternity care and coverage under the insurance law and section twenty-eight hundred three-n of this article, and suggest that expectant parents check their insurance policies for the details of their maternity coverage.

1-b. The informational leaflet shall also include information relating to the physical and mental health of the maternity patient after discharge from the hospital, including, but not limited to, information about maternal depression. The commissioner, in collaboration with the commissioner of mental health, shall review and update the information on maternal depression contained in the leaflet, as necessary. The informational leaflets shall be made available to patients in the top six languages spoken in the state, other than English, according to the latest available data from the United States Census Bureau.

1-c. The informational leaflet shall also include a description of the dangers of shaking infants and young children. The description shall include information on the effects of shaking infants and young children, appropriate ways to manage the causes of shaking infants and young children, and discussion on how to reduce the risks of shaking infants and young children.

1-d. The informational leaflet shall also include the recommendations from the American Academy of Pediatrics relating to safe sleep, including sleep space and sleep position, and discussion on how to reduce the risk of infant death through safe sleep practices. The information described in this subdivision may take the form of a video

in lieu of a leaflet.

2. Such leaflet shall also include statistics relating to the annual percentage of maternity related procedures performed at such hospital or birth center, as provided by the commissioner, including but not limited to the following:

- (a) the annual rate of cesarean sections, primary, repeat and total, performed at such facility;
- (b) the annual percentage of women with previous cesarean sections who have had a subsequent successful vaginal birth;
- (c) the annual percentage of deliveries by midwives;
- (d) the annual percentage of births utilizing electronic fetal monitoring listed on the basis of external and internal;
- (e) the annual percentage of births utilizing forceps, listed on the basis of low forceps delivery and mid forceps delivery;
- (f) the annual percentage of breech births delivered vaginally;
- (g) the annual percentage of births utilizing analgesia;
- (h) the annual percentage of births utilizing anesthesia including general, spinal, epidural, and paracervical listed on the basis of vaginal and cesarean births;
- (i) the annual percentage of births utilizing induction of labor;
- (j) the annual percentage of births utilizing augmentation of labor;
- (k) the annual percentage of vaginal births utilizing episiotomies;
- (l) whether birthing rooms are available for use in the facility;
- (m) whether rooming-in is available in the facility, on the basis of twenty-four hours a day or daytime;
- (n) whether the facility conducts safety drills to prepare for obstetric emergencies;
- (o) whether the facility participates in quality improvement initiatives;
- (p) whether the facility has an agreement and policy to arrange for emergent transfer of care for critically ill pregnant people/infants to higher levels of care (applicable only for those facilities that are not the designated regional perinatal center or a quaternary or tertiary care center with Level III-IV NICU);
- (q) whether the facility has a written community needs assessment plan to reduce racial disparities and address community needs;

(r) whether the facility offers, upon patient request, an autopsy for stillbirth; and

(s) whether the facility offers bereavement support for patients that have suffered a stillbirth or third trimester fetal loss.

3. Compilation of the statistics set out in subdivision two of this section shall be the responsibility of the commissioner.

4. Statistical information shall be presented in the most recent one year aggregate.

5. (a) The commissioner shall establish an immunization schedule for newborn children. The immunization schedule shall chart out recommended immunizations against certain diseases and illnesses and age-appropriate times for the administration of each immunization. The immunization schedule shall also include information on the importance of getting children immunized at the recommended ages. The immunization schedule shall also include the toll-free telephone number operated by the department as part of its immunization education efforts. The immunization schedule shall be in accordance with recommendations established by the New York state department of health.

(b) The commissioner shall provide the immunization schedule to the local registrars for distribution pursuant to paragraph (b) of subdivision one of section four thousand one hundred thirty-seven of this chapter.

6. Every hospital and birth center shall request that a parent and/or parents, which shall mean and include biological and adoptive parents, guardians, or other persons in parental relationship to a newborn child, if available, view (a) a video presentation, approved by the commissioner, on the dangers of shaking infants and young children, and the symptoms of shaken baby syndrome, and (b) a video presentation, approved by the commissioner, on the dangers of drowning for infants and young children. After viewing such video presentations or upon refusal to view such video presentations, the hospital or birth center shall request that such parent and/or parents sign a form stating that they have viewed or refused to view such video presentations. All training

materials and forms required to implement the provisions of this subdivision shall be provided by the commissioner.

* NB There are 2 § 2803-j's

*** § 2803-j. Nursing home nurse aide registry.** 1. The department shall develop and maintain, or cause to be developed and maintained, a nurse aide registry of individuals who have successfully completed a nurse aide training program approved by the commissioner or the commissioner of education or the accrediting body of other states or federal authorities including the military, and a competency evaluation program approved by the commissioner. The department, or any entity with which the department contracts, may charge a fee not to exceed one hundred sixty-five dollars, adjusted annually to reflect increases in the consumer price index for the purposes of implementing the competency evaluation program approved by the commissioner and maintaining the registry, as provided for in this section.

2. In accordance with federal law and regulation, no charges shall be imposed on a nurse aide for any costs for the nurse aide training or competency evaluation program.

3. The nurse aide registry shall include, but not be limited to, the following information:

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

(b) Name, address (at time competency test was passed), and date of birth, of individuals listed in the registry;

(c) Name and date of state approved training and competency evaluation program successfully completed by an individual; and

(d) In accordance with the provisions of section twenty-eight hundred three-d of this article, findings of instances of physical abuse, mistreatment, neglect or misappropriation of resident property by a nurse aide in a nursing home, and any brief statement by the nurse aide disputing the findings.

4. Notwithstanding any inconsistent provision of this article, unless otherwise required by federal law or regulation as a condition of federal aid, in which case such law or regulation shall be controlling and the provisions of paragraph a of subdivision seven of section twenty-eight hundred seven of this article shall not apply, the cost of any fee charged pursuant to subdivision one of this section paid by a residential health care facility shall be included in rates of payment determined in accordance with this article for such residential health care facility based on estimated costs for a prospective rate period and subsequently reconciled to actual expenses and statistics for such rate period by prospective adjustments of rates of payment.

* NB There are 2 § 2803-j's

§ 2803-k. In-patient nasogastric feeding procedures. The commissioner shall promulgate and administer regulations and policies governing the maximum size of nasogastric feeding tubes in hospitals and residential health care facilities to protect patients from undue discomfort.

§ 2803-l. Community service plans. 1. The governing body of a voluntary non-profit general hospital must issue an organizational mission statement identifying at a minimum the populations and communities served by the hospital and the hospital's commitment to meeting the health care needs of the community.

2. The governing body must at least every three years:

- (i) review and amend as necessary the hospital mission statement;
- (ii) solicit the views of the communities served by the hospital on such issues as the hospital's performance and service priorities;
- (iii) demonstrate the hospital's operational and financial commitment to meeting community health care needs, to provide charity care services and to improve access to health care services by the underserved; and
- (iv) prepare and make available to the public a statement showing on a combined basis a summary of the financial resources of the hospital and related corporations and the allocation of available resources to hospital purposes including the provision of free or reduced charge

services.

3. The governing body must at least annually prepare and make available to the public an implementation report regarding the hospital's performance in meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.

4. The governing body shall file with the commissioner its mission statement, its annual implementation report, and at least every three years a report detailing amendments to the statement and reflecting changes in the hospital's operational and financial commitment to meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.

§ 2803-m. Discharge of hospital patients to adult homes. (1) A patient about to be discharged as an inpatient from a hospital as defined in section twenty-eight hundred one of this article to an adult home, enriched housing program or residence for adults as defined in section two of the social services law, shall be referred only to such home, program or residence that is consistent with that patient's needs and that operates pursuant to section four hundred sixty of the social services law. No patient shall be directly referred to any facility that is on the "do not refer list" pursuant to subdivision fifteen of section four hundred sixty-d of the social services law; provided, however, that any patient who was a resident of an adult care facility at the time of his or her admission to the hospital shall be permitted to return to such adult care facility regardless of the status of its operating certificate.

(2) No patient about to be discharged as an inpatient from a hospital shall be referred to any adult home, enriched housing program or residence for adults, as defined in section two of the social services law, where the hospital has received a written notice pursuant to subdivision eleven of section four hundred sixty-d of the social services law that such home or residence is subject to enforcement

actions by the department; provided, however, that any patient who was a resident of an adult care facility at the time of his or her admission to the hospital shall be permitted to return to such adult care facility regardless of any enforcement actions. Referrals may resume when such enforcement actions are resolved.

§ 2803-n. Hospital care for maternity patients. 1. When a general hospital provides maternity care:

(a) Inpatient care for mothers and newborns shall be offered for not less than forty-eight hours after childbirth for any delivery other than a caesarean section, and for more than forty-eight hours when medically necessary. For a caesarean section, inpatient care for mothers and newborns shall be offered for not less than ninety-six hours after childbirth, and for more than ninety-six hours when medically necessary.

(b) Maternity care shall also include, at minimum, parent education, assistance and training in breast or bottle feeding, education on maternal depression, education on maternal depression screening and referrals, and the performance of any necessary or appropriate maternal and newborn clinical assessments and screenings and appropriate referrals. Notwithstanding this requirement, nothing in this paragraph is intended to result in the hospital charging any amount for such services in addition to the applicable charge for the maternity inpatient hospital admission.

(c) (i) The hospital shall adopt, implement and periodically update standard protocols for management of obstetric hemorrhage. Such protocols shall address early recognition and assessment and readiness to respond in a multidisciplinary manner. Such protocols shall utilize risk assessment tools such as the toolkit established or identified by the department under subdivision three of this section and shall include a response plan providing for the triage and transfer to higher level facilities if needed.

(ii) The hospital shall maintain and furnish protocols for management of obstetric hemorrhage required pursuant to subparagraph (i) of this paragraph to the department, immediately upon request.

2. This section shall not limit the mother's option to be discharged

earlier than the time periods established in subdivision one of this section.

3. The commissioner shall develop guidance to hospitals on obstetric hemorrhage protocols, in consultation with clinical experts, and develop or identify an existing toolkit on obstetric hemorrhage management, which may include a hemorrhage care checklist for use by hospitals as part of the protocols and guidance on simulation training. The commissioner shall post the guidance and toolkit on the department's website.

4. The hospital shall adopt, implement and periodically update standard protocols for management of other emergency medical conditions related to pregnancy for expectant mothers being admitted to the hospital or presenting to the emergency department, including but not limited to pre-term labor. Such protocols shall require the hospital to determine whether an expectant mother is experiencing an emergency medical condition, and upon making a diagnosis of an emergency medical condition, admit the expectant mother to the hospital or treat them in the emergency room for close observation and continuous monitoring until it is deemed medically safe for discharge or transfer in accordance with state and federal requirements including the federal Emergency Medical Treatment and Labor Act (EMTALA).

§ 2803-o. Hospital care for mastectomy, lumpectomy, and lymph node dissection patients. 1. When a general hospital provides mastectomy surgery, lymph node dissection or a lumpectomy, inpatient care shall be offered for a period as determined by the attending physician in consultation with the patient to be medically appropriate.

2. Every general hospital that provides mastectomy surgery, lymph node dissection or a lumpectomy shall provide information to the patient concerning the option of reconstructive surgery following such procedures, including both breast and chest wall reconstructive surgery and the availability of coverage for reconstructive surgery, in accordance with the provisions of sections three thousand two hundred

sixteen, three thousand two hundred twenty-one and four thousand three hundred three of the insurance law and applicable provisions of federal law. The information shall be provided to the patient in writing and in advance of obtaining consent to the surgical procedure. The information provided shall include at least the following:

- (a) a description of the various reconstructive options and the advantages and disadvantages of each. Such description shall include aesthetic flat closure as such term is defined by the National Cancer Institute;

- (b) a description of the provisions assuring coverage by public and private insurance plans of the costs related to reconstructive surgery under federal and state law;

- (c) a description of how a patient may access reconstructive care, including the potential of transferring care to a facility that provides reconstructive care or choosing to pursue reconstruction after completion of breast cancer surgery and chemo/radiotherapy, if warranted;

- (d) such other information as may be required by the commissioner.

§ 2803-p. Disclosure of information concerning family violence. 1. As used in this section:

- (a) Domestic violence shall mean acts as referred to in and qualified by section four hundred fifty-nine-a of the social services law.

- (b) Child abuse and maltreatment shall have the same meaning as provided for in section four hundred twelve of the social services law.

- (c) Family violence shall mean any act which would constitute domestic violence as defined in paragraph (a) of this subdivision or any act which would constitute child abuse and maltreatment as defined in paragraph (b) of this subdivision.

2. Every hospital having maternity and newborn services shall provide information concerning family violence to parents of newborn infants at any time prior to the discharge of the mother. Such information shall also be provided by every diagnostic and treatment center offering prenatal care services to women upon an initial prenatal care visit. The commissioner shall, in consultation with the state office for the

prevention of domestic violence and the department of social services, prepare, produce and transmit such notice to such facilities in quantities sufficient to comply with the requirements of this section. Such notice shall contain information which shall include but not be limited to the effects of family violence and the services available to women and children experiencing family violence.

Such information shall be in clear and concise language readily comprehensible. Nothing in this section shall preclude a facility from providing the notice required by this section as an addendum to, or in connection with, any other information required to be provided by any other provision of law, rule or regulation.

3. No cause of action of whatever nature or kind arising out of a failure to give or receive the notice required by this section shall accrue to any person against the state or any subdivision or agency thereof or any hospital or diagnostic and treatment center providing prenatal care services.

§ 2803-q. Family councils in residential health care facilities. 1. As used in this section:

(a) Family council means an organization of family members, friends, or representatives of two or more residents of a residential health care facility, organized to act under this section.

(b) Facility means the residential health care facility for which a family council is formed.

2. No residential health care facility may prohibit the formation of a family council, and, when requested by a member of the resident's family or the resident's representative, the family council shall be allowed to meet in a common meeting room of the facility, in private without facility staff at least once a month during mutually agreed upon hours.

3. Facility policies on family councils shall in no way limit the right of residents, family members, and family council members to meet independently with outside persons, including members of nonprofit or

government organizations or with facility personnel during non-working hours.

4. Family councils shall also be provided adequate space on a prominent bulletin board or other posting area for the display of meeting notices, minutes, newsletters, or other information pertaining to the operation or interest of the family council.

5. Staff or visitors may attend family council meetings, at the group's invitation.

6. The facility shall provide a designated staff person who shall be responsible for providing assistance and responding to written requests that result from family council meetings.

7. The facility shall consider the views and act upon the grievances and recommendations of a family council concerning proposed policy and operational decisions affecting resident care and life in the facility.

8. The facility shall respond in writing to written requests or concerns of the family council, within ten working days.

9. When a family council exists, the facility shall include notice of the family council meetings in at least a quarterly mailing, and shall inform family members or representatives of new residents who are identified on the admissions agreement, during the admissions process, or in the resident's records, of the existence of the family council. The notice shall include the time, place, and date of meetings, and the person to contact regarding involvement in the family council.

10. No facility shall willfully interfere with the formation, maintenance, or promotion of a family council. For the purposes of this subdivision, willful interference shall include, but not be limited to, discrimination or retaliation in any way against an individual as a result of his or her participation in a family council, or the willful scheduling of facility events in conflict with a previously scheduled family council meeting.

11. Violation of the provisions of this section shall constitute a violation of the resident's rights pursuant to this chapter.

§ 2803-r. Dissemination of information about the abandoned infant protection act. 1. All hospitals and clinics shall notify their prenatal care and obstetric patients of the provisions of the abandoned infant protection act, using materials provided by the office of children and family services. The department shall develop agreements with societies and organizations of medical practitioners under which the department or the office of children and family services shall provide materials to such societies to provide appropriate education and outreach concerning the abandoned infant protection act to their members and the public. Criminal penalties for violation pursuant to subdivisions one and two of section twelve-b of this chapter shall not apply to this section.

2. The commissioner, in consultation with the office of children and family services, shall adopt rules and regulations necessary to implement this section.

§ 2803-s. Access to product recall information. The commissioner shall require that every hospital and birth center distribute at the time of pre-booking or admission directly to each maternity patient and, upon request, to the general public an informational leaflet. Such leaflet shall be designed by the commissioner in conjunction with the secretary of state and shall contain information detailing how parents or guardians of infants and children can subscribe to the United States consumer product safety commission's e-mail subscription lists to receive consumer product recall and safety news by e-mail from the United States consumer product safety commission and such other material as deemed appropriate by the commissioner. Such leaflet shall be made available to hospitals and birth centers by the department on its website and shall be provided in English, as well as the top six languages other than English spoken in the state according to the latest available data from the United States Bureau of Census.

§ 2803-t. Preadmission information. 1. Any general hospital that provides preadmission information to a patient, shall offer a blind or visually impaired patient a large print version or, at the patient's or patient's representative's request, an audio recording, to be made available to such patient or such patient's representative on compact disc or other medium as the hospital may offer, or as an electronically transmitted digital file, in addition to a written copy of any preadmission information.

2. Each general hospital, during the intake and registration of each patient, shall obtain and record information as specified by the department in regulation or guidance to determine whether such patient requires a reasonable accommodation for a disability.

3. Nothing contained herein shall require a patient to answer the inquiries about a disability if they wish not to do so.

§ 2803-u. Hospital substance use disorder policies and procedures. 1. The office of alcoholism and substance abuse services, in consultation with the department, shall develop or utilize existing educational materials to be provided to general hospitals to disseminate to individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder during discharge planning pursuant to section twenty-eight hundred three-i of this article. Such materials shall include information regarding the various types of treatment and recovery services, including but not limited to: inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services; information for individuals to determine what type and level of treatment is most appropriate and what resources are available to them; and any other information the commissioner deems appropriate. General hospitals shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals for the appropriate use of medication-assisted treatment,

including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible.

2. Every general hospital shall: (a) within existing or in addition to current policies and procedures, develop, maintain and disseminate, written policies and procedures, for the identification, assessment and referral of individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder as defined in section 1.03 of the mental hygiene law;

(b) establish and implement training, within existing or in addition to current training programs, for all individuals licensed or certified pursuant to title eight of the education law who provide direct patient care regarding the policies and procedures established pursuant to this section; and

(c) except where an individual has come into the hospital under section 22.09 of the mental hygiene law, if the hospital does not directly provide substance use disorder services, then it shall refer individuals in need of substance use disorder services to and coordinate with substance use disorder services programs that provide behavioral health services, as defined in section 1.03 of the mental hygiene law.

3. Upon commencement of treatment, admission, or discharge of an individual with a documented substance use disorder or who appears to have or be at risk for a substance use disorder, including discharge from the emergency department, such hospital shall inform the individual of the availability of the substance use disorder treatment services that may be available to them through a substance use disorder services program.

4. The commissioner, in consultation with the commissioner of the office of alcoholism and substance abuse services, shall make regulations as may be necessary and proper to carry out the provisions of this section.

*** § 2803-v. Lymphedema information distribution.** 1. For the purposes

of this section, the term "lymphedema" shall mean an accumulation of fluid in the interstitial tissue that causes swelling, most often in the arms and/or legs, and occasionally in other parts of the body, from any cause.

2. The commissioner shall design an informational packet about lymphedema and shall require that every general hospital distribute such packet to all patients at high risk of developing lymphedema. Patients deemed high risk shall include:

(a) patients who experience any significant injury to soft tissue that could reasonably be expected, using sound medical judgment, as a result of severity and nature thereof, to compromise or cause to be ineffective the drainage of the lymphatic system;

(b) patients who experience recurrent or persistent bacterial infections that could reasonably be expected, using sound medical judgment, as a result of severity and nature thereof, to compromise or cause to be ineffective the drainage of the lymphatic system; or

(c) patients who have had corrective surgical procedures performed that may have interfered with the lymph drainage by severing local lymphatics in a manner that may jeopardize reconstitution and recovery of lymph drainage.

* NB There are 2 § 2803-v's

*** § 2803-v. Standing orders for newborn care in a hospital.** 1. A hospital may establish standing orders for the care of newborns in the hospital until the discharge of the newborn from the hospital following the birth, which may authorize an attending nurse to provide services and care to healthy newborns.

2. As used in this section, unless the context clearly requires otherwise:

(a) "Hospital" means a hospital that routinely provides perinatal care to newborns.

(b) "Attending practitioner" means the physician, nurse practitioner, physician assistant or midwife, acting within his or her lawful scope and terms of practice, attending the birth or postnatal care of a

newborn in a hospital.

(c) "Attending nurse" means a registered nurse attending the postnatal care of a newborn, acting within his or her lawful scope of practice.

(d) "Standing order" means a non-patient specific order for the care of healthy newborns in the hospital, established under this section.

3. A standing order may be implemented in the case of any newborn when (a) directed by the attending practitioner, or (b) in the absence of a specific direction by the attending practitioner, the attending nurse determines, in his or her professional judgment, that implementing the standing order for the newborn is clinically appropriate and consistent with the standing order, the hospital's policies and applicable regulations. The standing order shall not be implemented in a specific situation where the hospital's policies, the standing order, or applicable regulations provide otherwise.

4. (a) A standing order shall provide for the circumstances in which the condition or change in condition of the newborn or the newborn's mother, or other circumstances relating to providing services and care to the newborn, require departure from the terms of the standing order.

(b) Where an attending nurse implementing a standing order becomes aware of circumstances that, in his or her professional judgment, reasonably indicate a need to depart from the terms of the standing order, he or she shall so advise the attending practitioner. In such circumstances, if the attending nurse determines, in his or her professional judgment, that the health of the newborn requires departing from the standing order prior to receiving direction from the attending practitioner, the attending nurse may do so, consistent with his or her lawful scope of practice, the hospital's policies and applicable regulations.

(c) The standing order shall provide, including the times and manner, that an attending practitioner shall review and acknowledge in writing the services and care provided to the newborn under the standing order and the condition of the newborn.

5. (a) A standing order may provide for circumstances in which it shall not be implemented, or implemented only at the order of an

attending practitioner, which may include but not be limited to:

- (i) lack of or inadequate prenatal care;
- (ii) a birth not attended by an attending practitioner;
- (iii) a birth not occurring in a hospital; or
- (iv) a premature or low birth weight birth.

(b) A standing order shall be dated, timed, and authenticated promptly in the patient's medical record by the attending practitioner acting in accordance with law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules and regulations.

6. A standing order may be implemented only if the implementing hospital:

(a) establishes that the order has been reviewed and approved by the hospital's medical staff and nursing and pharmacy leadership, and signed by a physician affiliated with the hospital or, in the case of a midwifery birth center, by a midwife affiliated with the hospital;

(b) demonstrates that the order is consistent with nationally recognized evidence-based guidelines; and

(c) ensures that the periodic and regular review of the order is conducted by the hospital's medical staff and nursing and pharmacy leadership to determine the continuing usefulness and safety of the order.

7. A standing order is a medical regimen; it shall be consistent with the lawful scope of practice of a registered nurse.

8. The commissioner may make regulations governing the terms, procedures and implementation of standing orders.

* NB There are 2 § 2803-v's

*** § 2803-w. Independent quality monitors for residential health care facilities.** The department may require a residential health care facility to contract with an independent quality monitor selected, and on reasonable terms determined, by the department, pursuant to a selection process conducted notwithstanding sections one hundred twelve or one hundred sixty-three of the state finance law, for purposes of

monitoring the operator's compliance with a written and mandatory corrective plan and reporting to the department on the implementation of such corrective action, when the department has determined in its discretion that operational deficiencies exist at such facility that show:

1. a condition or conditions in substantial violation of the standards for health, safety, or resident care established in law or regulation that constitute a danger to resident health or safety;

2. a pattern or practice of habitual violation of the standards of health, safety, or resident care established in law or regulation; or

3. any other condition dangerous to resident life, health, or safety. Such written mandatory corrective plans shall include caps on administrative and general costs that are unrelated to providing direct care (including providing at least minimum staffing levels as determined by the department) or care coordination.

* NB There are 2 § 2803-w's

*** § 2803-w. Disclosure of information concerning pregnancy complications.** Every hospital offering maternity or women's wellness services shall provide the information developed pursuant to subdivisions two and four of section two hundred sixty-six of this chapter, as added by chapter 342 of the laws of 2014, to pregnant patients as clinically appropriate, but prior to discharge. In addition, such information shall be provided at the time of pre-booking to each prospective maternity patient and, upon request, to the general public. Such information shall also be provided by every diagnostic and treatment center offering prenatal care services upon the initial prenatal care visit.

* NB There are 2 § 2803-w's

§ 2803-x. Requirements related to nursing homes and related assets and operations. 1. The operator of a nursing home shall notify the

commissioner of any common or familial ownership of any corporation, other entity or individual providing services to the operator or the facility. Such information shall also be included in the residency agreement for prospective residents and as addendums for residents currently residing in the residential health care facility nursing home. The operator shall notify the department at least ninety days prior to entering into any new common or familial ownership of any corporation, or other entity or individual providing services to the operator of the facility. The operator shall also provide notification to all residents and their representatives, staff and their representatives, and the state office of the long-term care ombudsman.

2. The operator of a nursing home shall, on an annual basis, attest to the department, in a form determined by the department, to the accuracy of the information provided to the department under this section.

3. The operator of a nursing home may not enter into any arrangement to guarantee the debt or other obligation of a party which has not received establishment approval.

4. The operator of a nursing home shall notify the department and the state office of the long-term care ombudsman at least ninety days prior to executing a letter of intent or other contractual agreement related to:

a. the sale, mortgaging, encumbrance, or other disposition of the real property of the facility; and

b. the consulting, operations, staffing agency or other entity to be involved in the operations of the facility.

5. The operator of a nursing home shall notify all residents and their representatives, staff and their representatives, and the state office of the long-term care ombudsman within five days of executing a binding letter of intent or other contractual agreement as described in paragraphs a and b of subdivision four of this section.

6. Where the operator of a nursing home provides or purports to provide, by any contract, agreement or arrangement, for any party to carry out or be delegated any activity or responsibility relating to the nursing home, that shall not diminish any responsibility or liability that the operator would otherwise have for any such activity or responsibility or for the operation of the nursing home.

7. Any new owner or operator of a nursing home shall retain all employees of the nursing home for at least a sixty-day transition period, except for cause, and except for the nursing home administrator, the director of nursing and any other supervisors, or any controlling person, principal stockholder or principal member, and shall not reduce the wages or benefits, or modify any other terms and conditions of employment, economic or otherwise during the transition period. Nothing herein shall require any owner or operator to discontinue any pending disciplinary actions, including but not limited to termination, that were initiated before the sale of the nursing home. Nothing herein shall prevent an owner or operator from determining the overall size of the workforce at the facility, except as provided otherwise in this section or other applicable law.

8. In any instance where a nursing home is sold or otherwise transferred and used for a purpose which is not a health care purpose, the operator shall remit to the department an amount equivalent to the undepreciated value of capital assets for which the provider has been funded or reimbursed through Medicaid rate adjustments or otherwise funded or reimbursed with resources provided by the state for the purpose of improvement or transformation.

§ 2803-y. Provision of residency agreement. The operator of a residential health care facility shall provide to prospective residents who inquire about admission, and post on its website, a copy of the facility's entire approved residency agreement, including the non-governmental rates charged to residents.

*** § 2803-z. Transfer, discharge and voluntary discharge requirements for residential health care facilities.** 1. (a) No residential health care facility shall transfer or discharge a resident unless such transfer or discharge is necessary for the resident's health, safety, or welfare, such transfer or discharge is necessary to preserve the health, safety, or welfare of other residents, the facility discontinues operation or the resident has failed to pay or make arrangements for payment for a stay at the facility, unless stated otherwise by this section.

(b) Prior to a facility initiating a transfer or discharge of a resident, the facility shall use its best efforts, including compliance with applicable federal and state regulations, to secure appropriate placement or a residential arrangement for the resident, other than temporary housing assistance. For purposes of this section, "temporary housing assistance" shall include but not be limited to a family shelter, a shelter for adults, a hotel, an emergency apartment, a domestic violence shelter, or a safe house for refugees. No residential health care facility shall initiate a transfer or discharge of a resident to the home of another individual without the written consent of the resident and the other individual and the other individual has received and acknowledged the comprehensive discharge plan to address the resident's needs.

(c) At least thirty days prior to a facility-initiated transfer or discharge, the residential health care facility shall provide written notification of the transfer or discharge to the resident, the resident's lawful representative, if any, a family member of the resident, if known, and the long-term care ombudsman under section two hundred eighteen of the elder law. The notification shall be in a language and manner that is understandable to the resident and shall state the basis for the transfer or discharge, which shall be recorded in the resident's clinical record.

(d) A resident may be transferred or discharged if the facility is unable to meet the needs of the resident. In that case, the resident's clinical record shall document (i) the specific need or needs that cannot be met, (ii) the facility's attempts to meet the resident's needs, and (iii) the services available at the receiving facility.

(e) When a resident is being transferred or discharged because the

resident cannot be cared for safely, or is a danger to others, prior notice may be provided less than thirty days prior to the transfer or discharge but shall be provided as soon as practicable prior to transfer or discharge. The facility shall document in the resident's clinical record the risks to the resident or others if the resident were to remain in the facility.

(f) A residential health care facility may transfer or discharge a resident because the resident does not need residential health care facility services.

2. Where the resident's transfer or discharge is initiated by the resident and the clinical record notes that a family member or designated representative has requested notification, and such notification is otherwise lawful, the residential health care facility shall notify the family member or designated representative of the resident's voluntary transfer or discharge as soon as practicable after the resident initiates the voluntary transfer or discharge process and in no event more than forty-eight hours thereafter. The notice shall not be provided if the resident specifically requests that the family member or designated representative not be notified.

3. A residential health care facility shall not compel or attempt to compel an individual to voluntarily transfer or discharge from the facility. In the event a resident seeks a voluntary transfer or discharge, the facility shall document, as part of the resident's medical records, the reason the resident is seeking a transfer or discharge. If the resident declines to provide a reason, the facility shall document that in the resident's medical record.

4. Nothing in this section shall diminish a resident's rights to independent personal decisions and knowledge of available choices, nor shall it diminish the facility's responsibility to encourage and assist in the fullest possible exercise of those rights under section two thousand eight hundred three-c of this article, or other applicable law.

* NB There are 2 § 2803-z's

*** § 2803-z. Antimicrobial resistance prevention and education. 1.**

Every general hospital and nursing home shall comply with and meet all applicable requirements of the federal Medicare and Medicaid conditions of participation for antimicrobial stewardship programs in health care facilities, including training requirements regarding antimicrobial resistance and infection prevention and control. Additionally, such program shall incorporate an ongoing process to measure the impact of the program, including review, at least annually, of antimicrobial utilization data with development of response plans for high or increasing utilization.

2. The commissioner shall make such rules and regulations as may be necessary and proper to carry out the provisions of this section.

* NB There are 2 § 2803-z's

§ 2804. Units for hospital and health-related affairs. 1. The commissioner shall establish within the department a unit for hospital affairs to assist him in carrying out the provisions of this article.

2. The commissioner shall establish within the department a unit to assist him in carrying out the provisions of this article relating to facilities providing health-related service. He shall also appoint a council to advise on matters affecting health-related service.

*** § 2804-a. State task force on clinical practice guidelines and medical technology assessment.**

1. A state task force is hereby created on clinical practice guidelines and medical technology assessment which shall consist of sixteen members. At least half of the membership shall be physicians certified by specialty society boards officially recognized by the American Board of Medical Specialties. Such physician board members shall be selected from nominees recommended by specialty societies recognized by the American Board of Medical Specialties. Appointments shall be made as follows: six shall be appointed by the governor of

which at least two shall be from specialty society nominees; four shall be appointed by the temporary president of the senate of which at least two shall be from specialty society nominees; four shall be appointed by the speaker of the assembly of which at least two shall be from specialty society nominees; and one each shall be appointed by the minority leaders of the senate and assembly both of whom shall be specialty society nominees. The commissioner shall also serve as an ex officio member of the task force. The membership of the task force shall appoint a chairperson who shall be selected by a majority vote of the task force membership. All appointments shall be made by April first, nineteen hundred ninety-four.

2. For the purposes of this section, the following terms shall have the following meanings: (a) "clinical practice guidelines" shall mean systematically developed statements to assist physician and patient decisions about appropriate health care for specific clinical circumstances; and

(b) "medical technology" shall mean an instrument or unit of equipment or technique for use as a health related treatment, testing or diagnostic tool.

3. Task force members shall receive no compensation but shall be reimbursed for travel expenses incurred in the performance of their duties.

4. The task force may establish medical specialty advisory committees to assist in carrying out its responsibilities pursuant to this section.

5. The task force shall solicit the cooperation and participation of medical specialty organizations recognized by the American Board of Medical Specialties with clinical practice guideline experience. The state task force shall meet as necessary to fulfill its responsibilities.

6. The task force, in consultation with the commissioner, shall solicit specific research and/or project proposals from medical specialty societies recognized by the American Board of Medical

Specialties to promote the development and application of clinical practice guidelines and appropriate use of medical technology. Speciality societies, at their option, may incorporate the involvement of any other organization which they deem appropriate into their proposal. The task force shall then recommend to the commissioner specific research projects to be undertaken by such specialty society candidates for grants and contracts pursuant to subdivision fifteen of section two hundred six of this chapter. The task force shall not recommend any projects for the purpose of developing clinical practice guideline-based reimbursement methodologies or any other regulations.

7. The task force in cooperation with the medical specialty organizations recognized by the American Board of Medical Specialties shall issue a report to the governor and legislature by May first, nineteen hundred ninety-five which shall:

(i) describe the current status of practice guidelines, their uses and their impact on health care delivery and outcomes;

(ii) identify appropriate uses of practice guidelines and medical technology for purposes of improving health care quality and efficiency;

(iii) identify inappropriate uses or applications of practice guidelines and medical technology;

(iv) identify by what means the uses of practice guidelines should be facilitated, if appropriate or warranted; and

(v) identify what role, if any, state government should have relative to practice guidelines.

8. Staff of the department shall be made available to provide technical assistance to the task force as necessary.

* NB Expired June 30, 1996

§ 2805. Approval of hospitals; operating certificates. 1. No hospital shall be operated unless it shall: (a) possess a valid operating certificate issued pursuant to this article, which certificate may specify the kind or kinds of hospital services the facility is authorized to provide; (b) establish and maintain a uniform system of cost analysis approved by the commissioner; and (c) establish and

maintain a uniform system of reports and audits meeting the requirements of the commissioner.

2. (a) Application for an operating certificate for a hospital shall be made upon forms prescribed by the department. The application shall contain the name of the hospital, the kind or kinds of hospital service to be provided, the location and physical description of the institution, and such other information as the department may require.

(b) An operating certificate shall not be issued by the department unless it finds that the premises, equipment, personnel, rules and by-laws, standards of medical care, and hospital service are fit and adequate and that the hospital will be operated in the manner required by this article and rules and regulations thereunder.

(d) In the case of a state, county or municipal hospital an operating certificate shall not be issued by the department unless the hospital maintains a record of all charges and collections made by any person, partnership, organization or other entity whatsoever for services rendered to patients in such hospital, including, but not limited to, the person making the charge, the amount of the charge and the purpose for which the charge was made. Such record shall be made in a form acceptable to the commissioner and include any charges relating to admission to or discharge from such hospital.

§ 2805-a. Disclosure of financial transactions. 1. Every general hospital operating under the provisions of this article shall file with the commissioner of health within one hundred twenty days after the end of its fiscal year a certified report showing its financial condition and all of its financial transactions, including receipts and expenditures during the fiscal year.

The report shall be in such form as shall disclose all financial transactions as the commissioner of health may determine necessary to disclose accurately and specifically the financial condition of each hospital and its expenditures for the preceding year including but not limited to:

(a) Its operations and accomplishments.

(b) Its receipts and disbursements, or revenues and expenses, during such fiscal year in accordance with generally accepted accounting principles by categories, clinical services and departments as set forth under the by-laws of the institution and including but not limited to salaries and other benefits, personnel expenses, operating expenses, equipment and supplies, and all other direct and indirect disbursements allocated to each department and clinical service.

(c) Assets and liabilities at the end of its fiscal year including the status of reserves, depreciation, special or other funds, and including the receipts and payments of these funds.

(d) Loans and investments, interest, rents and profits from investments of the hospital.

(e) The location of any real property owned by the hospital.

2. Every general hospital shall also submit:

(a) A report of hospital expenses incurred in providing services during the period covered by the reports required under this section for which payment was not received and is not anticipated for such periods for which pool distributions pursuant to section twenty-eight hundred seven-c or section twenty-eight hundred seven-k of this article are made related to such expenses. The report shall be completed in accordance with regulations developed by the council and approved by the commissioner which shall include definitions for bad debts and charity care. The report shall identify as bad debts or charity care the cost of services provided to emergency inpatients, non-emergency inpatients, emergency ambulatory patients, clinic patients and referred or private ambulatory patients for which the hospital did not receive and does not anticipate payment.

(b) A statement of anticipated capital related expenses as defined in subdivision eight of section twenty-eight hundred seven-c of this article for the forthcoming calendar year at least one hundred twenty days, or such shorter period as the commissioner shall determine, prior to the commencement of such year. The report shall be completed in accordance with subdivision eight of section twenty-eight hundred seven-c of this article and any regulations adopted pursuant thereto.

3. Every general hospital shall submit a monthly report of gross

inpatient revenue received and within one hundred twenty days after the end of the calendar year a certified annual report of gross inpatient revenue received for hospital inpatient service provided on or after January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand. The reports shall be in such form as may be prescribed by the commissioner to accurately disclose gross inpatient revenue received.

* 4. The commissioner may, to effectuate the purpose of this article, vary the nature of the report required according to the size or capacity of the hospital.

The contents of all reports submitted hereunder shall be public information and such reports shall be available for public inspection under such conditions as the commissioner shall prescribe.

The commissioner of health when he has reasonable cause to believe that the books or records do not accurately reflect the financial condition and/or financial transactions of the hospital, may examine the books and records of the hospital, subpoena witnesses and documents and make such other investigation as is necessary to enable him to determine the facts relative thereto.

* NB Effective until October 1, 2025

* 4. (a) Every general hospital operating under the provisions of this article that is required to file an IRS Form 990 in accordance with federal regulations shall file with the commissioner, by July first of each calendar year, a completed copy of the most recent IRS Form 990 as submitted to the IRS, and the information the general hospital used to complete the IRS Form 990 in a manner prescribed by the department, showing how the hospital spent community benefit expenses, which shall include but not be limited to, information to identify the specific community benefit expenses supporting the hospital's local community. General hospitals operating under the provisions of this article that are not required to file an IRS Form 990 shall be required to submit information, in a manner prescribed by the department, showing how the hospital spent community benefit expenses in the same manner.

(b) The department shall compile the information reported in a report

issued and posted on the department's website by October first, two thousand twenty-six, and on an annual basis thereafter, and delivered to the governor, the speaker of the assembly, the temporary president of the senate, the chair of the assembly health committee, the chair of the senate health committee, the chair of the senate finance committee, the chair of the assembly ways and means committee, and the minority leaders of the assembly and the senate. The report shall include, at a minimum, information on:

(i) Total community benefit expenses in the state reported by each general hospital;

(ii) How such community benefit expenses were distributed in the aggregate across the following categories:

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

(2) Unreimbursed costs from Medicaid;

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

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

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

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

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

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

(iii) Details on negative-margin services that were reported by hospitals as part of community benefit expenses; and

(iv) Details on community benefit programs reported by hospitals as part of community benefit expenses.

* NB Effective October 1, 2025

* 5. The commissioner may, to effectuate the purpose of this article, vary the nature of the report required according to the size or capacity of the hospital.

The contents of all reports submitted hereunder shall be public information and such reports shall be available for public inspection under such conditions as the commissioner shall prescribe.

The commissioner of health when he has reasonable cause to believe that the books or records do not accurately reflect the financial condition and/or financial transactions of the hospital, may examine the books and records of the hospital, subpoena witnesses and documents and make such other investigation as is necessary to enable him to determine the facts relative thereto.

* NB Effective October 1, 2025

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

(a) "Emergency medical condition" shall mean:

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

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

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

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

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

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

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

(b) "Stabilize" shall mean, with respect to an emergency medical

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

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

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

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

(ii) in which the receiving facility:

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

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

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

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

2. Every general hospital as defined in this article shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient or any member of the patient's family concerning insurance, credit or payment of charges, provided, however, that the patient or a member of the patient's family shall agree to supply such information promptly after the patient's admission. However, no general hospital shall require any patient or member of the patient's family to write or to sign during those times when the religious tenets of such person temporarily prohibit such person from performing such acts. No general hospital shall transfer any patient to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered. Every general hospital which maintains facilities for providing out-patient emergency medical care must provide such care to any person who, in the opinion of a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice, requires such care.

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

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

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

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

(c) Obligation to provide treatment in accordance with applicable standard of care. Admission of an individual experiencing an emergency medical condition does not relieve a general hospital of the obligation to provide treatment that is within the hospital's abilities and consistent with the applicable standard of care.

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

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

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

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

of practice has signed a certification that:

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

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

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

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

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

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

(i) Nothing herein shall be interpreted as requiring the provision of care in violation of state or federal law.

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

5. A general hospital within a city with a population of one million

or more may request the emergency medical service of such city's health and hospitals corporation or any person, firm, organization or corporation providing ambulance service to divert ambulances to another hospital only under the following circumstances:

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

Diversion of patients with certain medical conditions which, in the best interest of the patients, require their transport directly to specialty referral centers shall be permitted following the designation of such specialty referral centers. Diversion of patients with psychiatric conditions to comprehensive psychiatric emergency programs, as such term is defined in section 1.03 of the mental hygiene law, and subject to the provisions of section 31.27 of such law, shall only be permitted following the designation of the programs by the commissioners of health and mental health to receive such patients.

6. Nothing in this section shall be construed to deny to a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice the right to evaluate the medical needs of persons arriving at the hospital for emergency treatment and to delay or deny medical treatment where, in the opinion of the health care practitioner, no emergency medical condition exists.

7. The staff of a general hospital shall: (a) inquire whether or not the person admitted has served in the United States armed forces. Such information shall be listed on the admissions form; (b) notify any admittee who is a veteran of the possible availability of services at a

hospital operated by the United States veterans health administration, and, upon request by the admittee, such staff shall make arrangements for the individual's transfer to a United States veterans health administration hospital, provided, however, that transfers shall be authorized only after it has been determined, according to accepted clinical and medical standards, that the patient's condition has stabilized and transfer can be accomplished safely and without complication; and (c) provide any admittee who has served in the United States armed forces with a copy of the "Information for Veterans concerning Health Care Options" fact sheet, maintained by the department of veterans' services pursuant to subdivision twenty-nine of section four of the veterans' services law prior to discharging or transferring the patient. The commissioner shall promulgate rules and regulations for notifying such admittees of possible available services and for arranging a requested transfer.

* NB Effective until July 1, 2027

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

(a) "Emergency medical condition" shall mean:

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

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

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

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

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

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

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

(b) "Stabilize" shall mean, with respect to an emergency medical condition described in subparagraph (i) of paragraph (a) of this subdivision, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or

occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in subparagraph (ii) of paragraph (a) of this subdivision, to deliver, including the placenta. "Stabilizing treatment" includes abortion pursuant to section twenty-five hundred ninety-nine-bb of this article when failure to provide an abortion will, within reasonable probability, result in material deterioration of the patient's condition upon or during transfer of the patient from the facility.

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

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

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

(ii) in which the receiving facility:

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

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

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

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

2. Every general hospital as defined in this article shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient or any member of the patient's family concerning insurance, credit or payment of charges, provided, however, that the patient or a member of the patient's family shall agree to supply such information promptly after the patient's admission. However, no general hospital shall require any patient or member of the patient's family to write or to sign during those times when the religious tenets of such person temporarily prohibit such person from performing such acts. No general hospital shall transfer any patient to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered. Every general hospital which maintains facilities for providing out-patient emergency medical care must provide such care to any person who, in the opinion of a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice, requires such care.

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

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

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

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

6. Nothing in this section shall be construed to deny to a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice the right to evaluate the medical needs of persons arriving at the hospital for emergency treatment and to delay or deny medical treatment where, in the opinion of the health care practitioner, no emergency medical condition exists.

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

* NB Effective July 1, 2027

§ 2805-c. Every private proprietary nursing home having a capacity of eighty patients or more may have a licensed medical doctor in attendance, upon the premises, for the care and treatment of patients.

§ 2805-d. Limitation of medical, dental or podiatric malpractice action based on lack of informed consent. 1. Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

2. The right of action to recover for medical, dental or podiatric malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body.

3. For a cause of action therefor it must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought.

4. It shall be a defense to any action for medical, dental or podiatric malpractice based upon an alleged failure to obtain such an informed consent that:

(a) the risk not disclosed is too commonly known to warrant disclosure; or

(b) the patient assured the medical, dental or podiatric practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical, dental or podiatric practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or

(c) consent by or on behalf of the patient was not reasonably

possible; or

(d) the medical, dental or podiatric practitioner, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition.

§ 2805-e. Reports of residential health care facilities. 1. Every residential health care facility operating under the provisions of this article shall, within one hundred twenty days after the end of its fiscal year, file an annual report with the commissioner of health. Said annual report shall be in such form and shall contain such information as shall be prescribed by the commissioner of health, including the following:

(a) A balance sheet of the facility as of the end of such fiscal year, setting forth assets and liabilities at such date, including all capital, surplus, reserve, depreciation and similar accounts.

(b) A statement of operations of the facility for such fiscal year, setting forth all revenues, expenses, taxes, extraordinary items and other credits or charges.

(c) The name and address of each of the following persons:

(i) the operator of the facility;

(ii) any person who, directly or indirectly, beneficially owns any interest in the land on which the facility is located;

(iii) any person who, directly or indirectly, beneficially owns any interest in the building in which the facility is located;

(iv) any person who, directly or indirectly, beneficially owns any interest in any mortgage, note, deed of trust or other obligation secured in whole or in part by the land on which or building in which the facility is located; and

(v) any person who, directly or indirectly, has any interest as lessor or lessee in any lease or sub-lease of the land on which or the building in which the facility is located.

(d) If the facility or any person named in response to paragraph (c) is a partnership, then the name and address of each partner.

(e) If the facility or any person named in response to paragraph (c) is a corporation, other than a corporation whose shares are traded on a national securities exchange or are regularly quoted in an over-the-counter market or which is a commercial bank, savings bank or savings and loan association, then the name and address of each officer, director, stockholder, and, if known, each principal stockholder and controlling person of such corporation.

(f) If any corporation named in response to paragraph (c) is a corporation whose shares are traded on a national securities exchange or are regularly quoted in an over-the-counter market or which is a commercial bank, savings bank or savings and loan association, then the name and address of the principal executive officers and each director and, if known, each principal stockholder of such corporation.

(g) If the facility paid or received an aggregate of five hundred dollars or more during the fiscal year in connection with transactions with any person named in response to paragraphs (c), (d), (e) or (f) or any affiliate of said person, a description of the transactions, naming the parties thereto and describing the relationships which require the transactions to be described and the goods, services, payment or other consideration received by each party to the transactions.

(h) If known, the nature and amount of any interest in, or relationship with, any other residential health care facility, held by any person named in response to paragraph (c) above, or by any affiliate of such person.

2. The following definitions shall be applicable to this section and to any reports filed pursuant hereto:

(a) "Affiliate" means:

(i) with respect to a partnership, each partner thereof;

(ii) with respect to a corporation, each officer, director, principal stockholder and controlling person thereof;

(iii) with respect to a natural person (a) each member of said person's immediate family, (b) each partnership and each partner thereof of which said person or any affiliate of said person is a partner, and (c) each corporation in which said person or any affiliate of said person is an officer, director, principal stockholder or controlling person.

(b) "Controlling person" of any corporation, partnership or other entity means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said corporation, partnership or other entity. Neither the commissioner nor any employee of the department nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a residential health care facility, shall by reason of his or her official position, be deemed a controlling person of any corporation, partnership or other entity nor shall any person who serves as an officer, administrator or other employee of any corporation, partnership or other entity or as a member of a board of directors or trustees of any corporation be deemed to be a controlling person of such corporation, partnership or other entity as a result of such position or his or her official actions in such position.

(c) "Immediate family" of any person includes each parent, child, spouse, brother, sister, first cousin, aunt and uncle of such person, whether such relationship arises by reason of birth, marriage or adoption.

(d) "Principal stockholder" of a corporation means any person who beneficially owns, holds or has the power to vote, ten percent or more of any class of securities issued by said corporation.

3. Every report filed by a residential health care facility pursuant to this section shall contain a written statement, sworn to by or on behalf of such facility and the operator of such facility, to the effect that the report is, to the best of such person's knowledge, true and complete and prepared in accordance with the provisions of this section.

§ 2805-f. Money deposited or advanced for admittance to nursing homes; waiver void; administration expenses. 1. Whenever money shall be deposited or advanced on a contract or license agreement for admittance to a nursing home as security for performance of the contract or agreement or to be applied to payments upon such contract or agreement when due, such money, with interest accruing thereon, until repaid or so

applied, shall continue to be the money of the person making such deposit or advance and shall be held in trust by the person with whom such deposit or advance shall be made and shall not be mingled with the personal moneys or become an asset of the person receiving the same.

2. The person receiving money so deposited or advanced shall deposit such money in an interest bearing account in a banking organization provided, however, that monies which are advanced pursuant to the provisions of subdivision one of this section for the purpose of being applied to payments in performance of a contract or license agreement when due need not be deposited in an interest bearing account until the sixty-first day next succeeding the day upon which such money was deposited or advanced. Such person shall thereupon notify in writing each of the persons making such security deposit or advance, giving the name and address of the banking organization in which the deposit of security money is made, and the amount of such deposit. Such person shall be entitled to receive, as administration expenses, a sum equivalent to one percent per annum upon the security money so deposited, which shall be in lieu of all other administrative and custodial expenses. The balance of the interest paid by the banking organization shall be the money of the person making the deposit or advance.

3. Any provision of such a contract or agreement whereby a person who so deposits or advances money waives any provision of this section is absolutely void.

4. Whoever knowingly and willfully:

(a) charges for any service provided to a recipient pursuant to title eleven of article five of the social services law, or a recipient pursuant to title XVIII of the federal social security act, money or other consideration at a rate in excess of the rates established by the department of health and certified by the director of the division of budget or established pursuant to title XVIII of the federal social security act, as the case may be; or

(b) charges, solicits, accepts or receives, in addition to any amount otherwise required to be paid pursuant to title eleven of article five

of the social services law, or pursuant to title XVIII of the federal social security act, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person not acting on behalf of such recipient or applicant for assistance under title eleven of article five of the social services law:

(i) as a precondition, express or implied, to admitting or expediting the admission of such recipient or applicant to a hospital or residential health care facility; or

(ii) as a requirement for the recipient's or applicant's continued stay in such facility,

when the cost of the services, provided therein to the recipient is paid for, in whole or in part, pursuant to title eleven of article five of the social services law, or pursuant to title XVIII of the federal social security act, shall be guilty of a class E felony.

§ 2805-g. Maintenance of records. 1. Every hospital shall maintain, as public information available for public inspection under such conditions as the commissioner shall prescribe, records containing copies of all inspection reports pertaining to the facility that have been filed with or issued by any governmental agency. Copies of such inspection reports shall be retained in said records for ten years from the date said reports are filed or issued.

2. The office of the commissioner and each regional office of the department shall make available for public inspection and at a nominal cost provide copies of all financial and inspection reports of hospitals filed with or issued by the department.

3. Nothing contained in this section shall be construed or deemed to require the public disclosure of confidential medical, social, personal or financial records of any patient. The commissioner shall adopt such regulations as may be necessary to give effect to the provisions of this section and to preserve the confidentiality of medical, social, personal or financial records of patients.

§ 2805-h. Immunizations. 1. Immunizations against poliomyelitis, mumps, measles, diphtheria and rubella. (a) It shall be the duty of the administrative officer or other person in charge of each hospital to inquire of each person in its care under the age of eighteen, or of a person in parental relation to such person, whether all necessary immunizations have been received for poliomyelitis, mumps, measles, diphtheria and rubella and, if not, to make available such immunizations and a certificate or certificates of such immunizations.

(b) This subdivision shall not apply to children whose parent, parents, or guardian are bona fide members of a recognized religious organization whose teachings are contrary to the practices herein required.

(c) If any physician licensed to practice medicine in this state certifies that such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to the child's health.

2. Immunizations against influenza for certain persons fifty or older and immunizations against pneumococcal for certain persons sixty-five or older. (a) Annually between September first and April first, it shall be the duty of the administrative officer or other person in charge of each general hospital to offer each admitted person age fifty or older vaccination against influenza virus. Such officer or person need not offer the vaccination to persons who have already received such vaccine or for whom it is otherwise inappropriate.

(b) It shall be the duty of the administrative officer or other person in charge of each general hospital to offer vaccination against pneumococcal disease to each admitted person age sixty-five or older in the hospital's care. Such officer or person need not offer the vaccination to people who have already received it, are not in need of a booster, or for whom it is otherwise inappropriate.

(c) Each general hospital shall adopt an influenza and pneumococcal immunization policy which shall include, but not be limited to, the following: procedures for identifying persons age fifty or older for influenza, sixty-five or older for pneumococcal disease and at the

discretion of the facility other individuals at risk; procedures for the offering of immunization against influenza virus upon admission or discharge to persons age fifty or older, between September first and April first, and pneumococcal disease upon admission or discharge to persons age sixty-five or older; procedures for ensuring that individuals offered immunization or their guardian receive information regarding the risks and benefits of vaccination; a standing order policy approved by the medical director or other appropriate physician which shall include, but not be limited to, an assessment for contra-indications; and a system for documenting vaccine administration, medical contra-indications, patient refusals and any post-vaccination adverse events.

(d) The commissioner may waive the requirements of this subdivision due to a shortage of influenza and/or pneumococcal vaccine.

3. Immunizations against influenza and Bordetella pertussis; neonatal intensive care units.

(a) It shall be the duty of each general hospital (i) with a neonatal intensive care unit to offer, annually between September first and April first, to every parent or person in parental relation who is reasonably anticipated to be a caregiver in the household of a newborn being treated in the neonatal intensive care unit vaccination against influenza virus; and (ii) having a newborn nursery or providing obstetric services to offer to every parent, person in parental relation or other person who is reasonably anticipated to be a caregiver of a newborn being treated in such hospital vaccination against Bordetella pertussis (whooping cough). If the parent or person in parental relation wishes to be vaccinated, the hospital shall provide the person with the vaccination. If the parent or person in parental relation declines the hospital offer or wishes to defer vaccination, the hospital shall provide information on where such person may be vaccinated. Such general hospital need not offer the vaccination to parents and persons in parental relation who have already received such vaccine or for whom it is medically inappropriate.

(b) Each general hospital shall adopt a policy for implementing this subdivision, documenting the offer of vaccine administration.

(c) The commissioner may waive the requirements of this subdivision

due to a shortage of influenza vaccine.

§ 2805-i. Treatment of sexual offense victims and maintenance of evidence in a sexual offense. 1. Every hospital providing treatment to alleged victims of a sexual offense shall be responsible for:

- * (a) maintaining sexual offense evidence and the chain of custody as provided in subdivision two of this section;

- * NB Effective until May 9, 2027

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

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

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

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

- (ii) have successfully completed a didactic and clinical training course and post course preceptorship as appropriate to scope of practice that aligns with guidance released by the commissioner.

- * NB Effective May 9, 2027

- * (b) informing sexual offense victims of the availability of rape crisis and local victim assistance organizations, if any, in the geographic area served by the hospital, and contacting a rape crisis or local victim assistance organization to establish the coordination of non-medical services, including but not limited to transportation within the geographic area served by that organization, upon the conclusion of initial medical services, free of charge from the medical facility to sexual offense victims who request such coordination and services;

* NB Effective until May 9, 2027

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

* NB Effective May 9, 2027

* (c) offering and making available appropriate HIV post-exposure treatment therapies; including the full regimen of HIV post-exposure prophylaxis in cases where it has been determined, in accordance with guidelines issued by the commissioner, that a significant exposure to HIV has occurred, and informing the victim that payment assistance for such therapies and other crime related expenses may be available from the office of victim services pursuant to the provisions of article twenty-two of the executive law. With the consent of the victim of a sexual assault, the hospital emergency room department shall provide or arrange for an appointment for medical follow-up related to HIV post-exposure prophylaxis and other care as appropriate; and

* NB Effective until May 9, 2027

* (c) Ensuring that such sexual assault forensic examiners maintain a current certification from the department, pursuant to regulations, in providing sexual assault examinations. The commissioner shall issue regulations consistent with subparagraph one of paragraph (b) of subdivision four-b of this section, establishing a process for individuals to apply for and receive certification upon meeting the required criteria, as well as a process for recertification.

* NB Effective May 9, 2027

* (d) ensuring sexual assault survivors are not billed for sexual assault forensic exams and are notified orally and in writing of the option to decline to provide private health insurance information and have the office of victim services reimburse the hospital for the exam pursuant to subdivision thirteen of section six hundred thirty-one of the executive law.

* NB Effective until May 9, 2027

* (d) maintaining sexual offense evidence and the chain of custody as provided in subdivision two of this section;

* NB Effective May 9, 2027

* (e) informing sexual offense victims of the availability of rape crisis and local victim assistance organizations, if any, in the geographic area served by the hospital, and contacting a rape crisis or

local victim assistance organization to establish the coordination of non-medical services, including but not limited to transportation within the geographic area served by that organization, upon the conclusion of initial medical services, free of charge from the medical facility to sexual offense victims who request such coordination and services;

* NB Effective May 9, 2027

* (f) offering and making available appropriate HIV post-exposure treatment therapies; including the full regimen of HIV post-exposure prophylaxis in cases where it has been determined, in accordance with guidelines issued by the commissioner, that a significant exposure to HIV has occurred, and informing the victim that payment assistance for such therapies and other crime related expenses may be available from the office of victim services pursuant to the provisions of article twenty-two of the executive law. With the consent of the victim of a sexual assault, the hospital emergency room department shall provide or arrange for an appointment for medical follow-up related to HIV post-exposure prophylaxis and other care as appropriate; and

* NB Effective May 9, 2027

* (g) ensuring sexual assault survivors are not billed for sexual assault forensic exams and are notified orally and in writing of the option to decline to provide private health insurance information and have the office of victim services reimburse the hospital for the exam pursuant to subdivision thirteen of section six hundred thirty-one of the executive law.

* NB Effective May 9, 2027

2. Sexual offense evidence shall be collected and maintained as follows:

* (a) All sexual offense evidence shall be kept in a locked, separate and secure area for twenty years from the date of collection; provided that such evidence shall be transferred to a new location(s) pursuant to this subdivision.

* NB Effective until December 2, 2027

* (a) All sexual offense evidence shall be kept in a locked, separate and secure area for twenty years from the date of collection or until the victim's fortieth birthday, whichever is later; provided that such evidence shall be transferred to a new location(s) pursuant to this

subdivision.

* NB Effective December 2, 2027

(b) Sexual offense evidence shall include, but not be limited to, slides, cotton swabs, clothing and other items. Where appropriate, such items shall be refrigerated and the clothes and swabs shall be dried, stored in paper bags, and labeled. Each item of evidence shall be marked and logged with a code number corresponding to the alleged sexual offense victim's medical record.

* (c) Upon collection, the hospital shall notify the alleged sexual offense victim that, after twenty years, the sexual offense evidence will be discarded in compliance with state and local health codes and that the alleged sexual offense victim's clothes or personal effects will be returned to the alleged sexual offense victim at any time upon request. The alleged sexual offense victim shall be given the option of providing contact information for purposes of receiving notice of the planned destruction of such evidence after the expiration of the twenty-year period.

* NB Effective until December 2, 2027

* (c) Upon collection, the hospital shall notify the alleged sexual offense victim that, after twenty years or until the victim's fortieth birthday, whichever is later, the sexual offense evidence will be discarded in compliance with state and local health codes and that the alleged sexual offense victim's clothes or personal effects will be returned to the alleged sexual offense victim at any time upon request. The alleged sexual offense victim shall be given the option of providing contact information for purposes of receiving notice of the planned destruction of such evidence after the expiration of the twenty-year period or until the victim's fortieth birthday, whichever is later.

* NB Effective December 2, 2027

(d) Until September thirtieth, two thousand twenty-two, or earlier if determined feasible by the director of budget, hospitals shall be responsible for securing long-term sexual offense evidence pursuant to this section, after which such storage shall be the responsibility of the office of victim services, provided, however, that law enforcement shall transfer sexual offense evidence that is reported to law enforcement but for which consent is later withdrawn to the office of victim services for long-term storage. Storage of reported kits

transferred to the office of victim services or retained by law enforcement shall comport with the provisions of this subdivision. Hospitals may enter into contracts with other entities that will ensure appropriate and secure long-term storage of sexual offense evidence pursuant to this section until September thirtieth, two thousand twenty-two.

(e) Beginning April first, two thousand eighteen, the department, the office of victim services, the division of criminal justice services and the division of state police shall jointly study, evaluate and make recommendations concerning the storage and monitoring of sexual offense evidence for twenty years, including studying options for the use of: state-owned or operated facilities; facilities owned or operated by local government or law enforcement agencies; and facilities owned or operated by private entities.

* (f) Between thirty and ten days prior to the transfer of sexual offense evidence to the office of victim services, hospitals shall make diligent efforts to notify the alleged sexual offense victim of the transfer of custody for the remainder of the twenty-year storage period.

* NB Effective until December 2, 2027

* (f) Between thirty and ten days prior to the transfer of sexual offense evidence to the office of victim services, hospitals shall make diligent efforts to notify the alleged sexual offense victim of the transfer of custody for the remainder of the twenty-year storage period or until the victim's fortieth birthday, whichever is later.

* NB Effective December 2, 2027

(g) On September thirtieth, two thousand twenty-two, or earlier if determined feasible by the director of budget, responsibility for long-term storage of sexual offense evidence shall transfer to the office of victim services.

(h) After September thirtieth, two thousand twenty-two, or earlier if determined feasible by the director of budget, hospitals shall ensure transfer of sexual offense evidence collected pursuant to this section to the office of victim services within ten days of collection of such evidence, while maintaining chain of custody.

* (i) At least ninety days prior to the expiration of the twenty-year storage period for any sexual offense evidence, the office of victim services shall make diligent efforts to contact the alleged sexual

offense victim to notify the alleged sexual offense victim that the sexual offense evidence will be discarded in compliance with state and local health codes and that the alleged sexual offense victim's clothes and personal effects will be returned to the alleged sexual offense victim upon request.

* NB Effective until December 2, 2027

* (i) At least ninety days prior to the expiration of the twenty-year storage period for any sexual offense evidence or until the victim's fortieth birthday, whichever is later, the office of victim services shall make diligent efforts to contact the alleged sexual offense victim to notify the alleged sexual offense victim that the sexual offense evidence will be discarded in compliance with state and local health codes and that the alleged sexual offense victim's clothes and personal effects will be returned to the alleged sexual offense victim upon request.

* NB Effective December 2, 2027

* (j) Notwithstanding any other provision in this section, sexual offense evidence shall not continue to be stored where: (i) such evidence is not privileged and law enforcement requests its release, in which case the custodian or custodians shall comply with such request; or (ii) such evidence is privileged and either (A) the alleged sexual offense victim gives permission to release the evidence to law enforcement, upon which the hospital collecting such evidence must record the collection of such evidence in the electronic tracking system and notify the appropriate law enforcement agency within forty-eight hours and law enforcement must retrieve the evidence within ten days of such notice and report such evidence in the statewide electronic tracking system pursuant to subdivision eight of this section, or (B) the alleged sexual offense victim signs a statement directing the custodian or custodians to dispose of the evidence, in which case the sexual offense evidence will be discarded in compliance with state and local health codes.

* NB Effective until December 2, 2027

* (j) (i) Notwithstanding any other provision in this section, sexual offense evidence shall not continue to be stored where: (A) such evidence is not privileged and law enforcement requests its release, in which case the custodian or custodians shall comply with such request;

or (B) such evidence is privileged and either (1) the alleged sexual offense victim gives permission to release the evidence to law enforcement, upon which the hospital collecting such evidence must record the collection of such evidence in the electronic tracking system and notify the appropriate law enforcement agency within forty-eight hours and law enforcement must retrieve the evidence within ten days of such notice and report such evidence in the statewide electronic tracking system pursuant to subdivision eight of this section, or (2) the alleged sexual offense victim signs a statement directing the custodian or custodians to dispose of the evidence, in which case the sexual offense evidence will be discarded in compliance with state and local health codes. Where the alleged sexual offense victim is under the age of eighteen, a vulnerable elderly person, or an incompetent or physically disabled person as defined in section 260.31 of the penal law, the office of victim services shall not destroy sexual offense evidence at the direction of a parent, guardian, conservator, or other party.

(ii) Where the alleged sexual offense victim is under the age of eighteen and had capacity to independently consent to a forensic rape exam, such victim may independently request the destruction of sexual offense evidence or may independently make decisions impacting the status of their kit as "reported" or "unreported" as defined in subparagraphs three and four of paragraph (g) of subdivision eight of this section.

* NB Effective December 2, 2027

* (k) Where the alleged sexual offense victim was under the age of eighteen at the time of the alleged sexual offense, the office of victim services shall, upon the victim's eighteenth birthday, make diligent efforts to contact the alleged sexual offense victim and provide information described in section six hundred forty-one of the executive law and subparagraphs one, five, six, seven and eight of paragraph (a) of subdivision six of this section.

* NB Effective December 2, 2027

3. Upon admittance or commencement of treatment of the alleged sexual offense victim, the hospital shall advise the victim of the availability of the services of a local rape crisis or victim assistance

organization, if any, to accompany the victim through the sexual offense examination. If after receiving such advice the sexual offense victim wishes the presence of a rape crisis or victim assistance advocate, the hospital shall contact the appropriate organization and request that one be provided, provided, however, that if in the professional judgment of the treating practitioner a delay in treatment is detrimental to the provision of medical treatment, then examination or treatment need not be delayed pending the arrival of such advocate and further provided that the presence or continued presence of such advocate does not interfere with the provision of necessary medical care to the victim.

4. No hospital or treating practitioner shall be liable in civil damages for failing to comply with the requirements of subdivision one, two or three of this section or acting in good faith to provide treatment as provided in subdivision three of this section.

4-a. On and after April first, two thousand one, a hospital providing treatment to alleged victims of sexual offenses shall be eligible to receive from the division of criminal justice services, at no cost, sexual offense evidence collection kits.

4-b. (a) The commissioner shall, with the consent of the directors of interested hospitals in the state and in consultation with the commissioner of the division of criminal justice services, designate hospitals in the state as the sites of a twenty-four hour sexual assault forensic examiner program. The hospital sites shall be designated in urban, suburban and rural areas to give as many state residents as possible ready access to the sexual assault forensic examiner program. The commissioner, in consultation with the commissioner of the division of criminal justice services, shall consider the following criteria when designating these sexual assault forensic examiner program sites:

(1) the location of the hospital;

(2) the hospital's capacity to provide on-site comprehensive medical services to victims of sexual offenses;

(3) the capacity of the hospital site to coordinate services for victims of sexual offenses including medical treatment, rape crisis counseling, psychological support, law enforcement assistance and

forensic evidence collection;

(4) the hospital's capacity to provide access to the sexual assault forensic examiner site for disabled victims;

(5) the hospital's existing services for victims of sexual offenses;

(6) the capacity of the hospital site to collect uniform data and insure confidentiality of such data; and

(7) the hospital's compliance with state and federally mandated standards of medical care.

(b) Each sexual assault forensic examiner program site designated pursuant to this subdivision shall comply with the requirements of subdivisions one, two and three of this section, and shall also provide treatment to the victim as follows:

(1) The victim shall, absent exigent circumstances, be met by a sexual assault forensic examiner within sixty minutes of arriving at the hospital, who shall be a nurse practitioner, physician assistant, registered nurse or physician specially trained in forensic examination of sexual offense victims and the preservation of forensic evidence in such cases and certified as qualified to provide such services pursuant to regulations promulgated by the commissioner. Such program shall assure that such a specially-trained forensic examiner is on-call and available on a twenty-four hour a day basis every day of the year.

(2) An examination of the victim shall be performed promptly by such forensic examiner in a private room designated for such examinations. An obstetrician/gynecologist or other appropriate medical doctor shall be readily available to the forensic examiner if there is a need for more specialized medical evaluation or treatment.

(3) Promptly after the examination is completed, the victim shall be permitted to shower, be provided with a change of clothing, be informed that a rape crisis or victim assistance organization providing victim assistance to the geographic area served by that hospital is available to provide transportation within the geographic area served by that organization, upon the conclusion of initial medical services, free of charge from the medical facility, and receive follow-up information, counseling, medical treatment and referrals for same.

(c) Nothing in this subdivision shall affect the existence or continued existence of any program in this state through which a trained nurse practitioner, physician assistant, registered nurse or physician

is providing appropriate forensic examinations and related services to survivors of sexual assault.

5. The commissioner shall promulgate such rules and regulations as may be necessary and proper to carry out effectively the provisions of this section. Prior to promulgating such rules and regulations, the commissioner shall consult with relevant police agencies, forensic laboratories, rape crisis centers, hospitals, and other such persons as the commissioner deems necessary. Such rules and regulations shall identify the offenses subject to the provisions of this section, provide a specific definition of sexual offense evidence and require each hospital to contact its local police agency and forensic laboratory to determine their specific needs or requirements.

6. (a) The department, in consultation with the division of criminal justice services, the office of victim services, hospitals, other health care providers and victim advocacy organizations, shall publish a sexual assault victim bill of rights for purposes of informing sexual offense victims of their rights under state law. Such bill of rights shall be prominently published on the department's website, in at least the ten most common languages spoken in this state, and distributed to hospitals as a document which shall be provided to every presenting sexual offense victim. The department may update the bill of rights as necessary to reflect changes in state law and more accurately explain the law. Such bill of rights shall be in plain, easy to understand language, and include the right of the victim to:

(1) consult with a local rape crisis or local victim assistance organization, to have a representative of such organization accompany the victim through the sexual offense examination, to have such an organization be summoned by the medical facility, police agency, prosecutorial agency or other law enforcement agency before the commencement of the physical examination or interview, pursuant to this section, and to have such organization provide transportation within the geographic area served by that organization, free of charge from the medical facility to sexual offense victims who request such services upon discharge;

(2) be offered and have made available at no cost appropriate

post-exposure treatment therapies, including a seven day starter pack of HIV post-exposure prophylaxis in accordance with paragraph (c) of subdivision one of this section and subdivision thirteen of section six hundred thirty-one of the executive law;

(3) a health care forensic examination at no cost and the right to be notified of the option to decline to provide private health insurance information and have the office of victim services reimburse the hospital for the examination under subdivision thirteen of section six hundred thirty-one of the executive law;

(4) receive information relating to and the provision of emergency contraception in accordance with section twenty-eight hundred five-p of this article;

(5) be offered contact information for the police agency, prosecutorial agency or other law enforcement agency with jurisdiction over the sexual offense and be informed, upon request of the victim, of the date and location at which such sexual offense evidence kit was assessed for Combined DNA Index System (CODIS) eligibility and analyzed, whether a CODIS eligible profile was developed and whether or not a DNA match was identified, provided, however, that the police agency, prosecutorial agency or other law enforcement agency serving the jurisdiction may temporarily delay release of such DNA match information to the victim, prior to the arrest of a suspect alleged to have committed such offense, if such agency documents in writing and notifies the victim that release of such information would compromise the successful investigation of such sexual offense;

* (6) be notified between thirty and ten days prior to the transfer of a sexual offense evidence kit from the hospital to another storage facility in accordance with paragraph (h) of subdivision two of this section, the right to have a sexual offense evidence kit maintained at an appropriate storage facility for twenty years from the date of collection, the right, if not previously consented to, to consent to release the evidence to law enforcement at any time during the twenty years from collection, and the right to be notified by such facility at least ninety days prior to the expiration of the twenty-year storage period in accordance with paragraph (k) of subdivision two of this section; and

* NB Effective until December 2, 2027

* (6) be notified between thirty and ten days prior to the transfer of a sexual offense evidence kit from the hospital to another storage facility in accordance with paragraph (h) of subdivision two of this section, the right to have a sexual offense evidence kit maintained at an appropriate storage facility for twenty years from the date of collection or until the victim's fortieth birthday, whichever is later, the right, if not previously consented to, to consent to release the evidence to law enforcement at any time during the twenty years from collection, and the right to be notified by such facility at least ninety days prior to the expiration of the twenty-year storage period in accordance with paragraph (i) of subdivision two of this section; and

* NB Effective December 2, 2027

(7) be notified by the prosecutorial agency with jurisdiction of judicial proceedings relating to their case in accordance with article twenty-three of the executive law; and

(8) decide whether or not the victim wishes to report the offense to law enforcement.

(b) Before a medical facility commences a physical examination of a sexual offense victim, or a police agency, prosecutorial agency or other law enforcement agency commences an interview of a sexual offense victim, the health care professional conducting the exam, police agency, prosecutorial agency or other law enforcement agency shall inform the victim of the victim's rights by providing a copy of this sexual assault victim bill of rights and offering to explain such rights.

7. (a) The division of criminal justice services and the office of victim services, in consultation with the division of state police forensic investigations center and the department, shall convene a working group to:

(1) address the creation of a coordinated tracking system for sexual offense evidence kits;

(2) assess and make recommendations related to the forensic testing of sexual offense evidence collection kits when a survivor declines to report to law enforcement; and

(3) make recommendations to strengthen existing sexual offense evidence collection and testing for all sexual offense evidence kits.

(b) The working group shall report its findings and recommendations to

the governor, the temporary president of the senate, and the speaker of the assembly on or before November thirtieth, two thousand twenty-six.

8. (a) The division of criminal justice services in consultation with the department, the office of victim services, the division of state police, and the New York State Coalition Against Sexual Assault shall develop a statewide electronic tracking system for reported evidence collection kits used to collect and preserve evidence of a sexual assault or other sex offense.

(b) The division of criminal justice services shall promulgate rules and guidelines to ensure that sexual offense evidence collection kits are trackable on a statewide electronic tracking system developed pursuant to this subdivision, and that survivors are given notice of how they may track their own reported evidence collection kit. Any law enforcement agency, forensic laboratory, or prosecutor that has taken custody of an evidence collection kit used for a forensic medical examination shall comply with the established protocols, rules and guidelines established by the division of criminal justice services pursuant to this paragraph.

(c) The statewide electronic tracking system shall:

(1) Track the location and status of each reported evidence collection kit from collection to final disposition;

(2) Allow a hospital, law enforcement agency, accredited crime laboratory, prosecutor, employees of the long-term sexual offense evidence storage facility, or any other entity providing a chain of custody for a reported evidence collection kit, to update and track the status and location of the reported evidence collection kits;

(3) Allow a survivor to anonymously track or receive updates regarding the status and location of such survivor's reported evidence collection kit; and

(4) Incorporate any relevant findings from the working group referenced in subdivision seven of this section.

(d) No later than December first, two thousand twenty-seven, any hospital, law enforcement agency, accredited crime laboratory, prosecutor, employee of the long-term sexual offense evidence storage facility, or any other entity providing a chain of custody for a reported evidence collection kit to update and track the status and

location of such kit, shall participate in the tracking system and comply with all established protocols, rules and guidelines. A participating entity shall be permitted to access the entity's tracking information through the statewide electronic tracking system.

(e) Records entered into the tracking system are confidential. Records relating to a reported evidence collection kit shall be accessed only by the survivor for whom the reported evidence collection kit was completed.

(f) The provisions of this subdivision shall apply to all reported evidence collection kits submitted prior to, on, or after the effective date of this subdivision.

(g) For purposes of this section:

(1) "evidence collection kit" shall mean a human biological specimen or specimens collected by a healthcare provider during a forensic medical examination from the victim of a sexual assault or other sex offense;

(2) "survivor" shall mean an individual who is the victim of a sexual offense from whom a human biological specimen or specimens were collected by a healthcare provider during a forensic medical examination;

(3) "reported evidence collection kit" means a sexual offense evidence kit in which the survivor has consented to evidence collection and forensic testing; and

(4) "unreported evidence collection kit" means a sexual offense evidence collection kit for which the survivor has not consented to or withdraws their consent to release to law enforcement.

§ 2805-j. Medical, dental and podiatric malpractice prevention program. 1. Every hospital shall maintain a coordinated program for the identification and prevention of medical, dental and podiatric malpractice. Such program shall include at least the following:

(a) The establishment of a quality assurance committee with the responsibility to review the services rendered in the hospital in order to improve the quality of medical, dental and podiatric care of patients and to prevent medical, dental and podiatric malpractice. Such committee shall oversee and coordinate the medical, dental and podiatric

malpractice prevention program and shall insure that information gathered pursuant to the program is utilized to review and to revise hospital policies and procedures. At least one member of the committee shall be a member of the governing board of the hospital who is not otherwise affiliated with the hospital in an employment or contractual capacity;

(b) A medical, dental and podiatric staff privileges sanction procedure through which credentials, physical and mental capacity and competence in delivering health care services are periodically reviewed, and reviewed as otherwise warranted in specific instances and circumstances, as part of an evaluation of staff privileges;

(c) The periodic review and the review as otherwise warranted in specific instances and circumstances of the credentials, physical and mental capacity and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment and other events that may result in claims of medical, dental or podiatric malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to paragraphs (a) through (e) of this subdivision concerning individual physicians, dentists and podiatrists within the physician's, dentist's or podiatrist's personnel or credential file maintained by the hospital;

(g) Education programs dealing with patient safety, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients and causes of malpractice claims for staff personnel engaged in patient care activities;

(h) Continuing education programs for medical, dental and podiatric staff in their areas of specialty; and

(i) Policies to ensure compliance with the reporting requirements of

section twenty-eight hundred three-e of this article and subdivision eleven of section two hundred thirty of this chapter.

(j) For the purposes of this section, the term "hospital" shall have the same meaning as is set forth in subdivision ten of section twenty-eight hundred one of this article.

2. Any person who, in good faith and without malice, provides information to further the purposes of the medical, dental and podiatric malpractice prevention program or who, in good faith and without malice, participates on the quality assurance committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any hospital, or any person acting on behalf of such hospital, who, in good faith and without malice, takes or fails to take any action as a result of a review conducted pursuant to paragraph (b) or (c) of subdivision one of this section, shall not be subject to an action for civil damages or other monetary relief as a result of such action or failure to act, provided, however, that nothing in this subdivision shall relieve any hospital of any liability in an action for medical, dental or podiatric malpractice based on an act or failure to act as a result of a review conducted pursuant to paragraph (b) or (c) of subdivision one of this section, and provided further that nothing herein shall affect the authority of the commissioner pursuant to this chapter.

3. The commissioner shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate to effectuate the purposes of this section.

§ 2805-k. Investigations prior to granting or renewing privileges. 1. Prior to granting or renewing professional privileges or association of any physician, dentist or podiatrist or hiring a physician, dentist or podiatrist, a hospital or facility approved pursuant to this article shall request from the physician, dentist or podiatrist and the physician, dentist or podiatrist shall be required to provide the following information:

(a) The name of any hospital or facility with or at which the

physician, dentist or podiatrist had or has any association, employment, privileges or practice;

(b) Where such association, employment, privilege or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical, dental or podiatric misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in such proceedings or actions, and any additional information concerning such proceedings or actions as the physician, dentist or podiatrist may deem appropriate;

(d) The substance of the findings in such actions or proceedings and any additional information concerning such actions or proceedings as the physician, dentist or podiatrist may deem appropriate;

(e) A waiver by the physician, dentist or podiatrist of any confidentiality provisions concerning the information required to be provided to hospitals pursuant to this subdivision; and

(f) Documentation that the physician, dentist or podiatrist has completed the course work or training as mandated by section two hundred thirty-nine of this chapter or section six thousand five hundred five-b of the education law. A hospital or facility shall not grant or renew professional privileges or association to a physician, dentist, or podiatrist who has not completed such course work or training.

(g) A verification by the physician, dentist or podiatrist that the information provided by the physician, dentist or podiatrist is true and accurate.

2. Prior to granting privileges or association to any physician, dentist or podiatrist, or hiring a physician, dentist or podiatrist, any hospital or facility approved pursuant to this article shall request from any hospital with or at which such physician, dentist or podiatrist had or has privileges, was associated, or was employed, the following information concerning such physician, dentist or podiatrist:

(a) Any pending professional medical conduct proceedings or any pending medical malpractice actions, in this state or another state;

(b) Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another; and

(c) Any information required to be reported by hospitals pursuant to section twenty-eight hundred three-e of this article.

3. If requested by the department, a hospital shall provide documentation that, prior to granting privileges, association or employing a physician, dentist or podiatrist, it has complied with the requirements of subdivisions one and two of this section and that, prior to renewing privileges, association or employment, it has complied with the requirements of subdivision one of this section. Copies of the information and documentation required pursuant to subdivisions one and two of this section shall be placed in the physician's, dentist's or podiatrist's personnel or credentials file maintained by the hospital.

4. Any hospital which receives a request for information from another hospital pursuant to subdivision one or two of this section shall provide such information concerning the physician, dentist or podiatrist in question to the extent such information is known to the hospital receiving such a request, including the reasons for suspension, termination, curtailment of employment or privileges at the hospital. Any hospital or hospital employee providing such information in good faith shall not be liable in any civil action for the release of such information.

§ 2805-1. Adverse event reporting. 1. (a) All hospitals shall be required to report events described by subdivision two of this section to the department in a manner and within time periods as may be specified by regulation of the department.

(b) For purposes of this section, "hospital" means any general hospital or diagnostic and treatment center.

2. The following adverse events shall be reported to the department:

(a) patients' deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards;

(b) fires in the hospital which disrupt the provision of patient care services or cause harm to patients or staff;

(c) equipment malfunction during treatment or diagnosis of a patient

which did or could have adversely affected a patient or hospital personnel;

(d) poisoning occurring within the hospital;

(e) strikes by hospital staff;

(f) disasters or other emergency situations external to the hospital environment which affect hospital operations; and

(g) termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.

3. Notwithstanding any provision of this section to the contrary, the commissioner is authorized, as appropriate in the interest of promoting patient safety, and after consulting with clinicians, hospital administrators, researchers, and consumers with expertise in the area of patient safety and quality improvement, to add, modify or eliminate one or more adverse events set forth in subdivision two of this section, by regulation, consistent with national consensus standards endorsed by the consensus-based entity selected for the purpose of pursuing certain activities relating to healthcare performance measurement by the U.S. Department of Health and Human Services pursuant to the Medicare Improvements for Patients and Providers Act (Pub. L. 110-275).

4. The hospital shall conduct an investigation of events described in paragraphs (a) through (d) of subdivision two of this section within thirty days of obtaining knowledge of any information which reasonably appears to show that such an event has occurred, provided that, if the hospital reasonably expects such investigation to extend beyond such thirty day period, the hospital shall notify the department of such expectation and the reason therefor, and shall inform the department of the expected completion date of the investigation. The hospital shall provide to the department a copy of the investigation report within twenty-four hours of completion. Nothing herein shall limit the authority of the department to conduct an investigation of events occurring in hospitals.

5. The department shall:

(a) analyze event reports, findings of the investigations, their root cause analyses, and corrective action plans to determine patterns of systemic failure in the health care system and identify successful methods to correct these failures; and

(b) communicate to facilities the department's conclusions, if any, regarding event reports, patterns of systemic failure, and recommendations for corrective action resulting from the analysis of submissions from facilities; and may release, in a format that does not identify specific patients and does not provide reasonable basis to believe that the information can be used to identify a patient; (i) analyses and findings derived from the adverse event data to hospitals or the public and (ii) adverse event data to researchers for patient safety research projects approved by the commissioner, subject to any terms and conditions imposed by the commissioner concerning the security and confidentiality of the data and their use; and provided that no such data, record, documentation or action subject to subdivision two of section twenty-eight hundred five-m of this article, shall be subject to disclosure under article six of the public officers law nor article thirty-one of the civil practice law and rules.

6. The commissioner shall establish protocols for hospital personnel where a patient under the age of eighteen years dies during transportation to the hospital or while at the hospital, under circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards. Such protocols shall address matters including, but not limited to, the following:

- (a) medical and social history, and examination of the patient;
- (b) preservation of evidence and chain of custody;
- (c) questioning of the patient's family, guardian or person in parental authority;
- (d) circumstances surrounding the injury resulting in death;
- (e) determination of the cause of death;
- (f) notification of law enforcement personnel; and
- (g) reporting requirements under title six of article six of the

social services law.

In developing such protocols, the commissioner shall consult with the office of children and family services, local departments of social services, coordinators of child fatality review teams established pursuant to section four hundred twenty-two-b of the social services law, law enforcement agencies, pediatricians preferably with expertise in the area of child abuse and maltreatment or forensic pediatrics, and such other persons as the commissioner deems necessary.

7. The commissioner shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate to effectuate the purposes of this section.

§ 2805-m. Confidentiality. 1. The information required to be collected and maintained pursuant to sections twenty-eight hundred five-j and twenty-eight hundred five-k of this article, reports required to be submitted pursuant to section twenty-eight hundred five-l of this article and any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be kept confidential and shall not be released except to the department or pursuant to subdivision four of section twenty-eight hundred five-k of this article.

2. Notwithstanding any other provisions of law, none of the records, documentation or committee actions or records required pursuant to sections twenty-eight hundred five-j and twenty-eight hundred five-k of this article, the reports required pursuant to section twenty-eight hundred five-l of this article nor any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to

the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.

3. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person, partnership, corporation, firm, society, or other entity on account of the communication of information in the possession of such person or entity, or on account of any recommendation or evaluation, regarding the qualifications, fitness, or professional conduct or practices of a physician, to any governmental agency, medical or specialists society, or hospital as required by sections twenty-eight hundred five-j, twenty-eight hundred five-k and twenty-eight hundred five-l of this article or any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter. The foregoing shall not apply to information which is untrue and communicated with malicious intent.

4. (a) Hospital sepsis data submitted to the department, shall for the initial phase of data collection be considered a "pilot phase", the purpose of which is to ensure the completeness and accuracy of reporting by hospitals.

(b) For data reported during the pilot phase, hospital identifiers shall be encrypted by the department in any and all public databases and reports. The department shall provide each hospital with an encryption key for that hospital only to permit access to its own performance data for internal quality improvement purposes. Hospital specific public reporting of sepsis data including, but not limited to risk adjusted sepsis mortality rates, may require up to, but no more than, two years of "pilot phase" collection depending on the validity and reliability outcomes of the data collected.

(c) As described in the regulations pertaining to the submission of data on sepsis to the department, consultation with appropriate national, hospital and expert stakeholders will assist in determining the appropriate public release of hospital performance.

(d) The department shall issue regular reports as needed to hospitals assessing the accuracy of the data submitted during the pilot phase and

provide guidance for improving the accuracy of data reporting.

(e) After the pilot phase is completed, all data submitted under this section and compiled in the database established herein and all public reports derived therefrom shall include hospital identifiers.

(f) Clinical performance data, including but not limited to individual hospital mortality rates adjusted for potential differences in risk factors and comparisons with state (or national, if available) averages, shall be developed and posted on the department's web site.

§ 2805-n. Child abuse prevention. All hospitals shall: (i) develop, maintain and disseminate written policies and procedures pursuant to title six of article six of the social services law and applicable provisions of article ten of the family court act, regarding the mandatory reporting of child abuse or neglect, reporting procedures and obligations of persons required to report, provisions for taking a child into protective custody, mandatory reporting of deaths, immunity from liability, penalties for failure to report and obligations for the provision of services and procedures necessary to safeguard the life or health of the child; and (ii) establish, and implement on an ongoing basis, a training program for all current and new employees regarding the policies and procedures established pursuant to this section.

§ 2805-o. Identification of veterans and their spouses by nursing homes, residential health care facilities, and adult care facilities. 1. Every nursing home and residential health care facility as defined in subdivisions two and three of section two thousand eight hundred one of this article and every adult care facility licensed and certified by the department pursuant to title two of article seven of the social services law or article forty-six-B of this chapter, including all adult homes, enriched housing programs, residences for adults, assisted living programs, and assisted living residences shall keep and maintain accurate records identifying veterans and their spouses residing within such facilities. Such information shall be solicited by nursing home and/or residential health care facility staff upon a patient's admission, noted on the admission form, and included with the patient's

file by asking the question "Have you or your spouse ever served in the United States military?". In the case of patients currently residing at such nursing homes or residential health care facilities, staff shall solicit such information by asking the question "Have you or your spouse ever served in the United States military?" from each patient residing at such institution and update the patient's file to indicate veteran status.

2. Every nursing home, residential health care facility and every adult care facility licensed and certified by the department pursuant to title two of article seven of the social services law or article forty-six-B of this chapter, including all adult homes, enriched housing programs, residences for adults, assisted living programs, and assisted living residences shall in writing advise all individuals identifying themselves as veterans or spouses of veterans that the department of veterans' services and local veterans' service agencies established pursuant to section fourteen of the veterans' services law to provide assistance to veterans and their spouses regarding benefits under federal and state law. Such written information shall include the name, address and telephone number of the New York state department of veterans' services, the nearest department of veterans' services office, the nearest county or city veterans' service agency and the nearest accredited veterans' service officer.

3. Every nursing home, residential health care facility and every adult care facility licensed and certified by the department pursuant to title two of article seven of the social services law or article forty-six-B of this chapter, including all adult homes, enriched housing programs, residences for adults, assisted living programs, and assisted living residences, with the permission of individuals identifying themselves as veterans or spouses of veterans, shall transmit such veteran status information to the division of veterans' services.

4. Any person who violates the provisions of this section shall be subject to a civil fine not to exceed fifty dollars per violation but in no event shall any fine exceed one thousand dollars.

§ 2805-p. Emergency treatment of rape survivors. 1. As used in this section:

(a) "Emergency contraception" shall mean one or more prescription drugs used separately or in combination to be administered or self-administered by a patient to prevent pregnancy within a medically recommended amount of time after sexual intercourse and dispensed for that purpose in accordance with professional standards of practice and determined by the United States Food and Drug Administration to be safe.

(b) "Emergency treatment" shall mean any medical examination or treatment provided by a hospital to a rape survivor following an alleged rape.

(c) "Rape" shall mean any act defined in section 130.25, 130.30 or 130.35 of the penal law.

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

2. Every hospital providing emergency treatment to a rape survivor shall promptly:

(a) provide such survivor with written information prepared or approved, pursuant to subdivision three of this section, relating to emergency contraception;

(b) orally inform such survivor of the availability of emergency contraception, its use and efficacy; and

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

3. The commissioner shall develop, prepare and produce informational materials relating to emergency contraception for distribution to and use in all hospitals in the state, in quantities sufficient to comply with the requirements of this section. The commissioner may also approve informational materials from medically recognized sources for the purposes of this section. Such informational material shall be in clear and concise language, readily comprehensible, in such varieties and forms as the commissioner shall deem necessary to inform survivors in

English and languages other than English. Such materials shall explain the nature of emergency contraception including its use and efficacy.

4. The commissioner shall promulgate all such rules and regulations as may be necessary and proper to implement the provisions of this section.

§ 2805-q. Hospital visitation by domestic partner. 1. No domestic partner or surrogate as defined by subdivision twenty-nine of section twenty-nine hundred ninety-four-a of this chapter shall be denied any rights of visitation of his or her domestic partner or of the patient or resident for whom he or she is the surrogate, when such rights are accorded to spouses and next-of-kin at any hospital, nursing home or health care facility.

2. For purposes of this section only, "domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

3. Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner

that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

§ 2805-r. Patients unable to verbally communicate. 1. The department shall make regulations concerning the treatment of general hospital patients who are unable to verbally communicate, for whatever reason, with a health care practitioner or aide.

2. Such regulations shall establish standards for a patient to have present during his or her period of admission a parent, guardian, representative or authorized helper to assist in the communication with health care personnel.

3. The standards established under this section shall be incorporated into the statement of rights and responsibilities adopted pursuant to paragraph (g) of subdivision one of section twenty-eight hundred three of this article.

§ 2805-s. Circulating nurse required. A registered nurse, qualified by training and experience in operating room nursing, shall be present as a circulating nurse in any and each separate operating room where surgery is being performed for the duration of the operative procedure. Nothing in this section precludes a circulating nurse from leaving the operating room as part of the operative procedure, leaving the operating room for short periods; or, in accordance with employee rules or regulations, being relieved during an operative procedure by another circulating nurse assigned to continue the operative procedure.

§ 2805-t. Clinical staffing committees and disclosure of nursing quality indicators. 1. Legislative intent. The legislature hereby finds and declares:

(a) Research demonstrates that nurses play a critical role in improving patient safety and quality of care;

(b) Appropriate staffing of general hospital personnel, including registered nurses available for patient care, assists in reducing errors, complications and adverse patient care events, improves staff safety and satisfaction, and reduces incidences of workplace injuries;

(c) Health care professional, technical, and support staff comprise vital components of the patient care team, bringing their particular skills and services to ensuring quality patient care;

(d) Ensuring sufficient staffing of general hospital personnel, including registered nurses, is an urgent public policy priority in order to protect patients and support greater retention of registered nurses and safer working conditions; and

(e) It is the public policy of the state to promote evidence-based nurse staffing standards and increase transparency of health care data and decision making based on the data.

2. Clinical staffing committee. (a) Each general hospital licensed pursuant to this article shall establish and maintain a clinical staffing committee, either by creating a new committee or assigning the functions of the clinical staffing committee to an existing committee, no later than January first, two thousand twenty-two.

(b) Where a collective bargaining agreement provides for a staffing committee, the required functions of the clinical staffing committee established pursuant to this section shall be incorporated into that committee. Any staffing or non-staffing committees established by a collective bargaining agreement, shall continue to function in accordance with the terms of the agreement, and the clinical staffing committee established by this section shall not limit or otherwise supplant the collective bargaining agreement.

(c) At least one-half of the members of the clinical staffing committee shall be registered nurses, licensed practical nurses, and ancillary members of the frontline team currently providing or supporting direct patient care and up to one-half of the members shall be selected by the general hospital administration and shall include but not be limited to the chief financial officer, the chief nursing officer, and patient care unit directors or managers or their designees.

The selection of the registered nurses, licensed practical nurses, and ancillary frontline team members of the committee shall be according to their respective collective bargaining agreements if there is one in effect at the general hospital for their bargaining unit. If there is no applicable collective bargaining agreement, the members of the clinical staffing committee who are registered nurses, licensed practical nurses, and ancillary members providing direct patient care shall be selected by their peers. Ancillary members of the frontline team on the committee shall include but are not limited to patient care technicians, certified nursing assistants, other non-licensed staff assisting with nursing or clerical tasks, and unit clerks.

3. Employee participation. Participation in the clinical staffing committee by a general hospital employee shall be on scheduled work time and compensated at the appropriate rate of pay. Clinical staffing committee members shall be fully relieved of all other work duties during meetings of the committee and shall not have work duties added or displaced to other times as a result of their committee responsibilities.

4. Primary responsibilities. Primary responsibilities of the clinical staffing committee shall include the following functions:

(a) Development and oversight of implementation of an annual clinical staffing plan. The clinical staffing plan shall include specific staffing for each patient care unit and work shift and shall be based on the needs of patients. Staffing plans shall include specific guidelines or ratios, matrices, or grids indicating how many patients are assigned to each registered nurse and the number of nurses and ancillary staff to be present on each unit and shift and shall be used as the primary component of the general hospital staffing budget.

(b) Factors to be considered and incorporated in the development of the plan shall include, but are not limited to:

(i) Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;

(ii) Measures of acuity and intensity of all patients and nature of the care to be delivered on each unit and shift;

(iii) Skill mix;

(iv) The availability, level of experience, and specialty certification or training of nursing personnel providing patient care, including charge nurses, on each unit and shift;

(v) The need for specialized or intensive equipment;

(vi) The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

(vii) Mechanisms and procedures to provide for one-to-one patient observation, when needed, for patients on psychiatric or other units as appropriate;

(viii) Other special characteristics of the unit or community patient population, including age, cultural and linguistic diversity and needs, functional ability, communication skills, and other relevant social or socio-economic factors;

(ix) Measures to increase worker and patient safety, which could include measures to improve patient throughput;

(x) Staffing guidelines adopted or published by other states or local jurisdictions, national nursing professional associations, specialty nursing organizations, and other health professional organizations;

(xi) Availability of other personnel supporting nursing services on the unit;

(xii) Waiver of plan requirements in the case of unforeseeable emergency circumstances as defined in subdivision fourteen of this section;

(xiii) Coverage to enable registered nurses, licensed practical nurses, and ancillary staff to take meal and rest breaks, planned time off, and unplanned absences that are reasonably foreseeable as required by law or the terms of an applicable collective bargaining agreement, if any, between the general hospital and a representative of the nursing or ancillary staff;

(xiv) The nursing quality indicators required under subdivision seventeen of this section;

(xv) General hospital finances and resources; and

(xvi) Provisions for limited short-term adjustments made by appropriate general hospital personnel overseeing patient care operations to the staffing levels required by the plan, necessary to

account for unexpected changes in circumstances that are to be of limited duration.

(c) Semiannual review of the staffing plan against patient needs and known evidence-based staffing information, including the nursing sensitive quality indicators collected by the general hospital.

(d) Review, assessment, and response to complaints regarding potential violations of the adopted staffing plan, staffing variations, or other concerns regarding the implementation of the staffing plan and within the purview of the committee.

5. Compliance provisions. (a) The clinical staffing plan shall comply with all federal and state laws and regulations and shall not diminish other standards contained in state or federal law and regulations, or the terms of an applicable collective bargaining agreement, if any.

(b) The clinical staffing plan shall comply with applicable laws and regulations, including, but not limited to:

(i) Regulations made by the department on burn unit staffing, liver transplant staffing, and operating room circulating nurse staffing;

(ii) Staffing regulations to be promulgated by the commissioner relating to staffing in intensive care and critical care units no later than January first, two thousand twenty-two. Such regulations shall consider the factors set forth in paragraph (b) of subdivision four of this section, standards in place in neighboring states, and a minimum standard of twelve hours of registered nurse care per patient per day;

(iii) Such other staffing standards or regulations as are currently in effect or may hereafter be established by the department or enacted by the legislature; and

(iv) The provisions of section one hundred sixty-seven of the labor law and any related regulations.

(c) The clinical staffing plan shall comply with and incorporate any minimum staffing levels provided for in any applicable collective bargaining agreement, including but not limited to nurse-to-patient ratios, caregiver-to-patient ratios, staffing grids, staffing matrices, or other staffing provisions.

6. Process for adoption of clinical staffing plans. (a) The clinical staffing committee shall produce the general hospital's annual clinical

staffing plan by July first of each year.

(b) Clinical staffing plans shall be developed and adopted by consensus of the clinical staffing committee. For the purposes of determining whether there is a consensus, the management members of the committee shall have one vote and the employee members of the committee shall have one vote, regardless of the actual number of members of the committee. Each side may determine its own method of casting its vote to adopt all or part of the clinical staffing plan.

(c) The general hospital shall adopt any clinical staffing plan that is wholly or partially recommended by a consensus of the clinical staffing committee. If there is no consensus on the recommended staffing plan or any of its parts, the chief executive officer of the general hospital shall use the officer's discretion to adopt a plan or partial plan for which there is no consensus. In this case, the chief executive officer shall provide a written explanation of the elements of the clinical staffing plan that the committee was unable to agree on, including the final written proposals from the two parties and their rationales. In no event may a chief executive officer fail to include in the adopted plan any staffing related terms and conditions of the plan that has previously been adopted through any applicable collective bargaining agreement.

(d) Each general hospital shall adopt and submit its first hospital clinical staffing plan under this section to the department no later than July first, two thousand twenty-two and annually thereafter. The plan submitted to the department shall, where applicable, include the written explanation from the chief executive officer and written proposals from the two parties regarding elements that the committee did not agree on as required in paragraph (c) of this subdivision. The submitted clinical staffing plan shall include data, from at least the previous year, on the frequency and duration of variations from the adopted clinical staffing plan, the number of complaints relating to the clinical staffing plan and their disposition, as well as descriptions of unresolved complaints submitted pursuant to paragraph (b) of subdivision seven of this section. The department shall post the plan as part of each individual general hospital's health profile on the website of the department no later than July thirty-first of each year. If the adopted clinical staffing plan is subsequently amended, the amended plan shall

be submitted to the department within thirty days of adoption. Adopted staffing plans shall be amended to include newly created units and existing units that undergo clinical or programmatic changes that fundamentally alter their character or nature. The department shall post amended staffing plans upon receipt.

7. Implementation of clinical staffing plans. (a) Beginning January first, two thousand twenty-three, and annually thereafter, each general hospital shall implement the clinical staffing plan adopted by July first of the prior calendar year, and any subsequent amendments, and assign personnel to each patient care unit in accordance with the plan.

(b) A registered nurse, licensed practical nurse, ancillary member of the frontline team, or collective bargaining representative may report to the clinical staffing committee any variations where the personnel assignment in a patient care unit is not in accordance with the adopted staffing plan and may make a complaint to the committee based on the variations.

(c) The clinical staffing committee shall develop a process to examine, respond to, and track data submitted under paragraph (b) of this subdivision. The clinical staffing committee may by consensus, as described in paragraph (b) of subdivision six of this section, determine a complaint resolved or dismissed. The clinical staffing committee shall also establish agreed upon rules and criteria to provide for confidentiality of complaints that are in the process of being examined or are found to be unsubstantiated. This subdivision does not infringe upon or limit the rights of any collective bargaining representative of employees, or of any employee or group of employees pursuant to applicable law, including without limitation any applicable state or federal labor laws.

8. Posting of staffing information. Each general hospital shall post, in a publicly conspicuous area on each patient care unit, the clinical staffing plan for that unit and the actual daily staffing for that shift on that unit as well as the relevant clinical staffing.

9. Retaliation and intimidation prohibited. A general hospital shall not retaliate against or engage in any form of intimidation of:

(a) An employee for performing any duties or responsibilities in connection with the clinical staffing committee; or

(b) An employee, patient, or other individual who notifies the clinical staffing committee or the hospital administration of the individual's staffing concerns.

10. Special considerations. Nothing in this section is intended to create unreasonable burdens on critical access hospitals under 42 U.S.C. Sec. 1395i-4 and sole community hospitals under 42 U.S.C. Sec. 1395ww(d)(5) related to the operation of their clinical staffing committees. Critical access and sole community hospitals may develop flexible approaches to accomplish the requirements of this section. Clinical staffing plans from such entities submitted to the department shall contain a description of any ways in which the general hospital's approach to creating the plan differed from the process outlined in this section. This subdivision does not relieve such entities from compliance with other provisions of this section related to the adoption, implementation and adherence to an adopted clinical staffing plan, reporting and disclosure, or other requirements of this section.

11. Investigations. (a) The department shall investigate potential violations of this section following receipt of a complaint with supporting evidence, of failure to:

(i) Form or establish a clinical staffing committee;

(ii) Comply with the requirements of this section in creating a clinical staffing plan;

(iii) Adopt all or part of a clinical staffing plan that is approved by consensus of the clinical staffing committee and submitted to the department;

(iv) Conduct a semiannual review of a clinical staffing plan; or

(v) Submit to the department a clinical staffing plan on an annual basis and any updates.

(b) The department shall initiate an investigation of unresolved complaints, that have first been submitted to the clinical staffing committee, regarding compliance with the clinical staffing plan, personnel assignments in a patient care unit or staffing levels, or any other requirement of the adopted clinical staffing plan, excluding

complaints determined by the clinical staffing committee to be resolved or dismissed as determined by consensus of the clinical staffing committee as described in paragraph (b) of subdivision six of this section.

(c) The department shall initiate an investigation after making an assessment that there is a pattern of failure to resolve complaints submitted to the clinical staffing committee or a pattern of failure to reach consensus on the adoption of all or part of a clinical staffing plan. In the case of a pattern of failure to resolve complaints or to reach consensus on the adoption of all or part of a clinical staffing plan, the department shall determine if the pattern was due to one of the parties routinely refusing to resolve complaints or reach consensus.

(d) Any department investigation of a complaint under this subdivision shall consider whether unforeseeable emergency circumstances as defined in subdivision fourteen of this section contributed to the failure of the general hospital to comply with this section.

(e) After an investigation conducted under paragraph (a) or (b) of this subdivision, if the department determines that there has been a violation, the department shall require the general hospital to submit a corrective plan of action within forty-five days of the presentation of findings from the department to the hospital. If the department determines after investigation under paragraph (c) of this subdivision that the general hospital representatives on the clinical staffing committee were responsible for a pattern of not resolving complaints or for a pattern of not reaching consensus, the department shall require the general hospital to submit a corrective action plan within forty-five days of the presentation of findings to the general hospital. If the department finds that the frontline staff representatives on the clinical staffing committee were responsible for a pattern of not resolving complaints or for a pattern of not reaching consensus, the department shall not require the general hospital to submit a corrective action plan or impose a civil penalty on the general hospital pursuant to subdivision twelve of this section.

12. Civil penalties. In the event that a general hospital fails to submit or submits but fails to implement a corrective action plan in response to a violation or violations found by the department based on a

complaint filed pursuant to paragraph (a), (b) or (c) of subdivision eleven of this section, the department may impose a civil penalty as authorized by section twelve of this chapter for all violations asserted against the general hospital, until the general hospital submits or implements a corrective action plan or takes other action directed by the department.

13. Posting of penalties and related information. The department shall maintain for public inspection, including posting on the general hospital profile on the department website, records of any civil penalties, administrative actions, or license suspensions or revocations imposed on general hospitals under this section.

14. Unforeseeable emergency circumstances. (a) For purposes of this section, "unforeseeable emergency circumstance" means:

- (i) Any officially declared national, state, or municipal emergency;
- (ii) When a general hospital disaster plan is activated; or
- (iii) Any unforeseen disaster or other catastrophic event that immediately affects or increases the need for health care services.

(b) In determining whether a general hospital has violated its obligations under this section to comply with the general hospital's clinical staffing plan, it shall not be a defense that it was unable to secure sufficient staff if the lack of staffing was foreseeable and could be prudently planned for or involved routine nurse staffing needs that arose due to typical staffing patterns, typical levels of absenteeism, and time off typically approved by the employer for vacation, holidays, sick leave, and personal leave.

15. Complaints. Nothing in this section shall be construed to preclude the ability to submit a complaint to the department as provided for under this chapter. Nothing in this section shall be construed as supplanting other complaint mechanisms established by a general hospital, including mechanisms designed to aid in compliance with other federal, state or local laws. Nothing in this section shall be construed as limiting or supplanting the rights of employees and their collective bargaining representatives to fully enforce any and all rights under the terms of a collective bargaining agreement. An employer shall not assert

or attempt to assert a claim that enforcement of the collective bargaining agreement is barred or limited by any provisions of this section.

16. Annual report. (a) The department shall submit an annual report to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate and the governor on or before December thirty-first of each year. This report shall include the number of complaints submitted to the department, the disposition of these complaints, the number of investigations conducted, and the associated costs for complaint investigations, if any.

(b) Prior to the submission of the report, the commissioner shall convene a stakeholder workgroup consisting of hospital associations and unions representing nurses and other ancillary members of the frontline team. The stakeholder workgroup shall review the report prior to its submission to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate.

17. Disclosure of nursing quality indicators. (a) Every facility with an operating certificate pursuant to the requirements of this article shall make available to the public information regarding nurse staffing and patient outcomes as specified by the commissioner by rule and regulation. The commissioner shall promulgate rules and regulations on the disclosure of nursing quality indicators providing for the disclosure of information including at least the following, as appropriate to the reporting facility:

(i) The number of registered nurses providing direct care and the ratio of patients per registered nurse, full-time equivalent, providing direct care. This information shall be expressed in actual numbers, in terms of total hours of nursing care per patient, including adjustment for case mix and acuity, and as a percentage of patient care staff, and shall be broken down in terms of the total patient care staff, each unit, and each shift.

(ii) The number of licensed practical nurses providing direct care. This information shall be expressed in actual numbers, in terms of total hours of nursing care per patient including adjustment for case mix and

acuity, and as a percentage of patient care staff, and shall be broken down in terms of the total patient care staff, each unit, and each shift.

(iii) The number of unlicensed personnel utilized to provide direct patient care, including adjustment for case mix and acuity. This information shall be expressed both in actual numbers and as a percentage of patient care staff and shall be broken down in terms of the total patient care staff, each unit, and each shift.

(iv) Incidence of adverse patient care, including incidents such as medication errors, patient injury, decubitus ulcers, nosocomial infections, and nosocomial urinary tract infections.

(v) Methods used for determining and adjusting staffing levels and patient care needs and the facility's compliance with these methods.

(vi) Data regarding complaints filed with any state or federal regulatory agency, or an accrediting agency, and data regarding investigations and findings as a result of those complaints, degree of compliance with acceptable standards, and the findings of scheduled inspection visits.

(b) Such information shall be provided to the commissioner of any state agency responsible for licensing or accrediting the facility, or responsible for overseeing the delivery of services either directly or indirectly, to any employee of a general hospital or the employee's collective bargaining agent, if any, and to any member of the public who requests such information directly from the facility. Written statements containing such information shall state the source and date thereof.

(c) The commissioner shall make regulations to provide a uniform format or form for complying with the reporting requirements of subparagraphs (i), (ii) and (iii) of paragraph (a) of this subdivision, allowing patients and the public to clearly understand and compare staffing patterns and actual levels of staffing across facilities. Such uniform format or form shall allow facilities to include a description of additional resources available to support unit level patient care and a description of the general hospital. The information required by subparagraphs (i), (ii) and (iii) of paragraph (a) of this subdivision, reported in a manner determined by the commissioner, shall be filed with the department electronically on a quarterly basis and shall be available to the public on the department's website. The regulations

shall take effect no later than December thirty-first, two thousand twenty-two. Information required to be provided pursuant to subparagraphs (i), (ii) and (iii) of paragraph (a) of this subdivision shall be made available to the public no later than July first, two thousand twenty-three.

18. Advisory commission. (a) There is hereby established an independent advisory commission, composed of nine experts in staffing standards and quality of patient care, including: three experts in nursing practice, quality of nursing care or patient care standards, one of whom shall be appointed by the governor, one of whom shall be appointed by the speaker of the assembly and one of whom shall be appointed by the temporary president of the senate; three representatives of unions representing nurses, one of whom shall be appointed by the governor, one of whom shall be appointed by the speaker of the assembly and one of whom shall be appointed by the temporary president of the senate; and three members representing general hospitals, one of whom shall be appointed by the governor, one of whom shall be appointed by the speaker of the assembly and one of whom shall be appointed by the temporary president of the senate. The members of the commission shall serve at the pleasure of the appointing official. Members of the commission shall keep confidential any information received in the course of their duties and may only use such information in the course of carrying out their duties on the commission, except those reports required to be issued by the commission under this section, which may only include de-identified information.

(b) The advisory commission shall convene from time to time in order to evaluate the effectiveness of the clinical staffing committees required by this section. Such review shall evaluate the following metrics, including but not limited to quantitative and qualitative data on whether staffing levels were improved and maintained, patient satisfaction, employee satisfaction, patient quality of care metrics, workplace safety, and any other metrics the commission deems relevant. The commission shall also review the annual report submitted by the department and make recommendations to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate as set forth in paragraph (d) of

this subdivision.

(c) The advisory commission may collect and shall be provided all relevant information, necessary to carry out its functions, from the department and other state agencies. The commission may also invite testimony by experts in the field and from the public. In making its recommendations to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate, the commission shall analyze relevant data, including data and factors set forth in paragraph (b) of subdivision four of this section related to clinical staffing plans. The commission may also make recommendations for additional or enhanced enforcement mechanisms or powers to address general hospital failure to comply with this section and recommend the appropriation of funding for the department to enforce this section or to assist general hospitals in hiring additional staff to comply with this section.

(d) The advisory commission shall submit to the speaker of the assembly, the temporary president of the senate and the chairs of the health committees of the assembly and senate, and make available to the public a report that makes recommendations to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate for further legislative action, if any, in order to improve working conditions and quality of care in general hospitals pursuant to this section and its intent.

(e) The commission shall submit its report and recommendations to the speaker of the assembly, the temporary president of the senate, and the chairs of the health committees of the assembly and senate no later than October thirty-first, two thousand twenty-four, once three years of staffing plans have been submitted to the department pursuant to this section.

(f) Members of the commission shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties hereunder.

(g) The legislature may appropriate funding for the commission to hire staff or consultants and provide for the operation of the commission as reasonably necessary to fulfill its functions.

§ 2805-u. Credentialing and privileging of health care practitioners providing telemedicine services. 1. For purposes of this section:

(a) "Distant site hospital" means a hospital licensed pursuant to this article or a hospital licensed by another state, that has entered into an agreement with an originating hospital to make available one or more health care practitioners that are members of its clinical staff to the originating hospital for the purposes of providing telemedicine services. To qualify as a distant site hospital for purposes of this article, a hospital licensed by another state must comply with the federal regulations governing participation by hospitals in Medicare.

(b) "Health care practitioner" shall mean a person licensed pursuant to article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-three, one hundred thirty-nine, one hundred forty, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four or one hundred fifty-nine of the education law, or as otherwise authorized by the commissioner.

(c) "Originating hospital" means the hospital at which a patient is located at the time telemedicine services are provided to him or her.

(d) "Telemedicine" means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient's health care while such patient is at the originating site and the health care provider is at a distant site.

2. When telemedicine services are provided to an originating hospital's patients pursuant to an agreement with a distant site hospital, the originating hospital may, in lieu of satisfying the requirements set forth in section twenty-eight hundred five-k of this article, rely on the credentialing and privileging decisions made by the distant site hospital in granting or renewing privileges to a health care practitioner who is a member of the clinical staff of the distant site hospital, provided that:

- (a) the distant site hospital participates in Medicare and Medicaid;
- (b) each health care practitioner providing telemedicine is licensed to practice in this state;
- (c) the distant site hospital, in accordance with requirements

otherwise applicable to that hospital, collects and evaluates all credentialing information concerning each health care practitioner providing telemedicine services, performs all required verification activities, and acts on behalf of the originating site hospital for such credentialing purposes;

(d) the distant site hospital reviews periodically, at least every two years, and as otherwise warranted based on outcomes, complaints or other circumstances, the credentials, privileges, physical and mental capacity, and competence in delivering health care services of each health care practitioner providing telemedicine services, consistent with requirements otherwise applicable to that hospital; reports the results of such review to the originating hospital; and notifies the originating hospital immediately upon any suspension, revocation, or limitation of such privileges;

(e) with respect to each distant site health care practitioner who holds privileges at the originating hospital, the originating hospital conducts a periodic internal review, at least every two years, of the distant site practitioner's performance of these privileges and provides the distant site hospital with such performance information for use in the distant hospital's periodic appraisal of the distant site physician or health care practitioner. Such information shall include, at a minimum, all adverse events that result from the telemedicine services provided by the distant site health care practitioner to the originating hospital's patients, all complaints the originating hospital has received about the distant site practitioner, and any revocation, suspension or limitation of the distant site practitioner's privileges by the originating hospital; and

(f) the agreement entered into between the originating site hospital and distant site hospital shall be in writing and shall, at a minimum:

(i) provide the categories of health care practitioners that are eligible candidates for appointment to the originating hospital's clinical staff,

(ii) require the governing body of the distant site hospital to comply with the Medicare conditions of participation governing the appointment of medical staff with regard to the health care practitioners providing telemedicine services,

(iii) itemize the credentialing information to be collected and the

required verification activities to be performed by the distant site hospital and relied upon by the originating hospital in considering the recommendations of the distant site hospital,

(iv) require each distant site health care practitioner providing telemedicine services to be licensed to practice in this state and privileged at the distant site hospital,

(v) require the distant site hospital to provide to the originating hospital a current list of each distant site health care practitioner's privileges at the distant site hospital, and

(vi) require the distant site hospital to conduct a periodic review consistent with requirements otherwise applicable to that hospital, at least every two years, and as otherwise warranted based on outcomes, complaints or other circumstances, the credentials, privileges, physical and mental capacity, and competence in delivering health care services of each health care practitioner providing telemedicine services; to provide the originating hospital with the results of such review; and to notify the originating hospital immediately upon any suspension, revocation, or limitation of such privileges.

3. Nothing in this section shall be construed as allowing an originating hospital to delegate its authority over and responsibility for decisions concerning the credentialing and granting staff membership or professional privileges to health care practitioners providing telemedicine services.

4. Notwithstanding any contrary provision of law, an originating hospital shall not be required to provide a physical examination or to maintain recorded medical history including immunizations for a health care provider providing consultations solely through telemedicine from a distant site hospital.

§ 2805-v. Observation services. 1. If a general hospital provides observation services, such services shall be provided in accordance with this section, and regulations adopted by the council and approved by the commissioner.

2. Observation services may be provided for such period of time as is permitted by the commissioner by regulation. Such regulations shall be consistent with federal policies for providing observation services to beneficiaries, as set forth in title XVIII of the federal social security act (medicare), except where necessary, in the discretion of the commissioner, to protect and promote patient care and safety.

3. Based on the clinical needs of the patient, which shall be determined in prompt fashion by appropriate staff, and the availability of services to meet those needs and patient safety, a general hospital shall determine (a) the proper clinical location for the care of a specific patient requiring observation services, including whether or not to provide such services in a distinct physical space, and (b) the appropriate oversight of observation services.

4. Every general hospital providing observation services shall develop and adopt policies and procedures for observation services, including: (a) assignment of a provider who will be responsible for the care of the patient and timely discharge from observation services; (b) clinical criteria for observation assignment and discharge; and (c) integration with quality assurance activities of the hospital.

5. The commissioner shall develop outpatient rates for observation services provided in accordance with this section to patients eligible for payments made by state governmental entities.

§ 2805-w. Patient notice of observation services. 1. Every general hospital shall provide patients who are placed into observation services by such general hospital with an oral and written notice within twenty-four hours of such placement that the patient is not admitted to the hospital and is under observation status. Such written notice shall be signed by the patient or the patient's legal representative to acknowledge receipt and shall include, but not be limited to, the following information:

(a) a statement that observation status may affect the patient's Medicare, Medicaid and/or private insurance coverage for the current

hospital services, including medications and other pharmaceutical supplies, as well as coverage for any subsequent discharge to a skilled nursing facility or home and community based care; and

(b) that the patient should contact his or her insurance plan to better understand the implications of being placed in observation status.

2. The commissioner shall develop and make available guidance on the notice as described in this section.

§ 2805-x. Hospital-home care-physician collaboration program. 1. The purpose of this section shall be to facilitate innovation in hospital, home care agency and physician collaboration in meeting the community's health care needs. It shall provide a framework to support voluntary initiatives in collaboration to improve patient care access and management, patient health outcomes, cost-effectiveness in the use of health care services and community population health. Such collaborative initiatives may also include payors, skilled nursing facilities and other interdisciplinary providers, practitioners and service entities.

2. For purposes of this section:

(a) "Hospital" shall include a general hospital as defined in this article or other inpatient facility for rehabilitation or specialty care within the definition of hospital in this article.

(b) "Home care agency" shall mean a certified home health agency, long term home health care program or licensed home care services agency as defined in article thirty-six of this chapter.

(c) "Payor" shall mean a health plan approved pursuant to article forty-four of this chapter, or article thirty-two or forty-three of the insurance law.

(d) "Practitioner" shall mean any of the health, mental health or health related professions licensed pursuant to title eight of the education law.

3. The commissioner is authorized to provide financing including, but not limited to, grants or positive adjustments in medical assistance

rates or premium payments, to the extent of funds available and allocated or appropriated therefor, including funds provided to the state through federal waivers, funds made available through state appropriations and/or funding through section twenty-eight hundred seven-v of this article, as well as waivers of regulations under title ten of the New York codes, rules and regulations, to support the voluntary initiatives and objectives of this section.

4. Hospital-home care-physician collaborative initiatives under this section may include, but shall not be limited to:

(a) Hospital-home care-physician integration initiatives, including but not limited to:

(i) transitions in care initiatives to help effectively transition patients to post-acute care at home, coordinate follow-up care and address issues critical to care plan success and readmission avoidance;

(ii) clinical pathways for specified conditions, guiding patients' progress and outcome goals, as well as effective health services use;

(iii) application of telehealth/telemedicine services in monitoring and managing patient conditions, and promoting self-care/management, improved outcomes and effective services use;

(iv) facilitation of physician house calls to homebound patients and/or to patients for whom such home visits are determined necessary and effective for patient care management;

(v) additional models for prevention of avoidable hospital readmissions and emergency room visits;

(vi) health home development;

(vii) development and demonstration of new models of integrated or collaborative care and care management not otherwise achievable through existing models; and

(viii) bundled payment demonstrations for hospital-to-post-acute-care for specified conditions or categories of conditions, in particular, conditions predisposed to high prevalence of readmission, including those currently subject to federal/state penalty, and other discharges with extensive post-acute needs;

(b) Recruitment, training and retention of hospital/home care direct care staff and physicians, in geographic or clinical areas of demonstrated need. Such initiatives may include, but are not limited to,

the following activities:

(i) outreach and public education about the need and value of service in health occupations;

(ii) training/continuing education and regulatory facilitation for cross-training to maximize flexibility in the utilization of staff, including:

(A) training of hospital nurses in home care;

(B) dual certified nurse aide/home health aide certification; and

(C) dual personal care aide/HHA certification;

(iii) salary/benefit enhancement;

(iv) career ladder development; and

(v) other incentives to practice in shortage areas; and

(c) Hospital - home care - physician collaboratives for the care and management of special needs, high-risk and high-cost patients, including but not limited to best practices, and training and education of direct care practitioners and service employees.

(d) Collaborative programs to address disparities in health care access or treatment, and/or conditions of higher prevalence, in certain populations, where such collaborative programs could provide and manage services in a more effective, person-centered and cost-efficient manner for reduction or elimination of such disparities.

(i) Such programs may target one or more disparate conditions, or areas of under-service, evidenced in defined populations, including but not be limited to:

(A) cardiovascular disease;

(B) hypertension;

(C) diabetes;

(D) chronic kidney disease;

(E) obesity;

(F) asthma;

(G) sickle cell disease;

(H) sepsis;

(I) lupus;

(J) breast, lung, prostate and colorectal cancers;

(K) geographic shortage of primary care, prenatal/obstetric care, specialty medical care, home health care, or culturally and linguistically compatible care;

- (L) alcohol, tobacco, or substance abuse;
- (M) post-traumatic stress disorder and other conditions more prevalent among veterans of the United States military services;
- (N) attracting members of minority populations to the field and practice of medicine; and
- (O) such other areas approved by the commissioner.

(ii) Collaborative hospital-home care-physician, and as applicable additional partner, models may include under such disparities programs:

- (A) service planning and design;
- (B) recruitment of specialty personnel and/or specialty training of professionals or other direct care personnel (including physicians, home care and hospital staffs), patients and informal caregivers;
- (C) continuing medical education and clinical training for physicians, follow-up evaluations, and supporting educational materials;
- (D) use of evidenced-based approaches and/or best practices to treatment;
- (E) reimbursement of uncovered services;
- (F) bundled or other integrated payment methods to support the necessary, coordinated and cost-effective services;
- (G) regulatory waivers to facilitate flexibility in provider collaboration and person-centered care;
- (H) patient/family peer support and education;
- (I) data collection, research and evaluation of efficacy; and/or
- (J) other components or innovations satisfactory to the commissioner.

(iii) Nothing contained in this paragraph shall prevent a physician, physicians group, home care agency, or hospital from individually applying for said grant.

(iv) The commissioner shall consult with physicians, home care agencies, hospitals, consumers, statewide associations representative of such participants, and other experts in health care disparities, in developing an application process for grant funding or rate adjustment, and for request of state regulatory waivers, to facilitate implementation of disparities programs under this paragraph.

5. Hospitals and home care agencies which are provided financing or waivers pursuant to this section shall report to the commissioner on the patient, service and cost experiences pursuant to this section,

including the extent to which the project goals are achieved. The commissioner shall compile and make such reports available on the department's website.

§ 2805-y. Identification and assessment of human trafficking victims.

1. As used in this section:

(a) "human trafficking victim" shall have the meaning set forth in section four hundred eighty-three-aa of the social services law;

(b) "subject facility" shall mean a general hospital, public health center, diagnostic center, treatment center or outpatient department;

(c) "subject facility personnel" shall mean nursing, medical, social work and other clinical care personnel, and security personnel in the subject facility service units; and

(d) "subject facility service units" shall mean the service units of the subject facility that include the following areas: (i) emergency services; (ii) pediatrics; (iii) obstetrics and gynecology; (iv) orthopedics; (v) internal medicine; (vi) family medicine; (vii) radiology; (viii) surgery; (ix) psychiatry; and (x) dental services to the extent the subject facility maintains a dental clinic, center or department on site of the subject facility.

2. Every subject facility shall provide for the identification, assessment, and appropriate treatment or referral of persons suspected as human trafficking victims, and in the case of persons under eighteen years old, the reporting of such persons as an abused or maltreated child if required under title six of article six of the social services law. The subject facility shall establish and implement written policies and procedures under this section which shall apply to all subject facility service units.

3. Every subject facility shall provide, on an ongoing basis, to all subject facility personnel training regarding the policies and procedures established under this section, including training in the recognition of indicators of a human trafficking victim and the responsibilities of such personnel in dealing with persons suspected as human trafficking victims. Such training may be incorporated as part of

the subject facility's existing training programs, provided that the training includes all of the requirements of this section.

4. The commissioner may identify organizations or providers for consideration by subject facilities to provide training under this section. The commissioner may, in consultation with the office of temporary and disability assistance and the office of children and family services, make regulations under this section.

§ 2805-z. Hospital domestic violence policies and procedures. 1. Every general hospital shall: (a) develop, maintain and disseminate written policies and procedures for the identification, assessment, treatment and referral of confirmed or suspected cases of domestic violence; (b) establish, and implement on an ongoing basis, a training program for all nursing, medical, social work and other clinical personnel, and security personnel working in hospital service units regarding the policies and procedures established pursuant to this section; and (c) designate a staff member to contact the domestic violence or victim assistance organization identified by the commissioner under subdivision three of this section providing victim assistance to the geographic area served by such hospital to establish the coordination of services to domestic violence victims.

2. Upon admittance or commencement of treatment of a confirmed or suspected domestic violence victim, such hospital shall advise the victim of the availability of the services of a domestic violence or victim assistance organization. If after receiving such advice the domestic violence victim wishes the presence of a domestic violence or victim assistance advocate, such hospital shall contact the appropriate organization and request that one be provided.

3. The commissioner shall promulgate such rules and regulations as may be necessary and proper to carry out effectively the provisions of this section. Prior to promulgating such rules and regulations, the commissioner shall consult with the office for the prevention of domestic violence and other such persons as the commissioner deems

necessary to develop a model policy for hospitals to utilize in complying with this section and to identify the domestic violence or victim assistance organizations operating in each hospital's geographic area, a list of which the commissioner shall provide to hospitals with the model policy.

§ 2806. Hospital operating certificates; suspension or revocation. 1.

A hospital operating certificate may be revoked, suspended, limited or annulled by the commissioner on proof that: (a) the hospital has failed to comply with the provisions of this article or rules and regulations promulgated thereunder; or (b) a general hospital has refused or failed to admit or to provide for necessary emergency care and treatment for an unidentified person brought to it in an unconscious, seriously ill or wounded condition. A hospital operating certificate shall be revoked, limited or annulled by the commissioner upon revocation, limitation or annulment by the public health council of approval of establishment of such hospital.

2. No hospital operating certificate shall be revoked, suspended, limited or annulled without a hearing, except for operating certificates revoked, limited or annulled because of revocation, limitation, or annulment of establishment approval.

Also, an operating certificate may be temporarily suspended or limited without a hearing for a period not in excess of sixty days upon written notice to the hospital and opportunity for a hearing following a finding by the department that the public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any patient. The department may also, consistent with applicable federal law and regulations, prohibit or limit the placement of new patients in a residential health care facility without a hearing for a period not in excess of sixty days upon written notice to such facility and opportunity for a hearing upon a determination that such facility no longer substantially meets the requirements of this article and the regulations thereunder and that such deficiencies do not pose an

imminent danger to the health and safety of any patient, provided, however, that the department shall not make such a determination with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that such facility no longer substantially meets the requirements of this article, to correct its deficiencies and following this period, has been given written notice and opportunity for a hearing. Provided, however, that any delay in the hearing process during the sixty-day period occasioned by the hospital shall toll the running of said suspension or limitation and shall not abridge the full time provided for in this subdivision. Upon such finding and notice the power of the commissioner temporarily to suspend or limit a hospital operating certificate shall include, but shall not be limited to, the power to:

- (a) prohibit or limit the placement of new patients in the hospital;
- (b) remove or cause to be removed some or all of the patients in the hospital;
- (c) suspend or limit or cause to be suspended or limited the payment of any governmental funds to the hospital.

At any time subsequent to the suspension or limitation of any operating certificate pursuant to this subdivision, the hospital may request the department to reinspect the hospital to redetermine whether a specific condition or practice continues to exist. After the receipt of such a request the department shall reinspect the hospital within ten days and in the event that the previously found condition or practice has been eliminated the suspension or limitation shall be withdrawn. If the condition or practice has not been eliminated, the commissioner shall not thereafter be required to reinspect the hospital during the temporary period of suspension or limitation. Nor shall the commissioner be required to reinspect upon request during a temporary period of suspension or limitation any hospital whose operating certificate has been temporarily suspended or limited due to the existence of a continuing pattern of conditions or practices which poses imminent danger to the health and safety of any patient.

3. The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the

hearing, shall be served in person or mailed by registered or certified mail to the hospital at least ten days before the date fixed for the hearing. The hospital shall file with the department not less than three days prior to the hearing a written answer to the charges.

4. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant.

5. (a) Except as provided in paragraphs (b) and (d) of this subdivision, anything contained in this section or in a certificate of relief from disabilities or a certificate of good conduct issued pursuant to article twenty-three of the correction law to the contrary notwithstanding, a hospital operating certificate of a hospital under control of a controlling person as defined in paragraph (a) of subdivision twelve of section twenty-eight hundred one-a of this article, or under control of any other entity, shall be revoked upon a finding by the department that such controlling person or any individual, member of a partnership or shareholder of a corporation to whom or to which an operating certificate has been issued, has been convicted of a class A, B or C felony, or a felony related in any way to any activity or program subject to the regulations, supervision, or administration of the department or of the office of temporary and disability assistance or in violation of the public officers law in a court of competent jurisdiction in the state, or of a crime outside the state which, if committed within the state, would have been a class A, B or C felony or a felony related in any way to any activity or program subject to the regulations, supervision, or administration of the department or of the office of temporary and disability assistance or in violation of the public officers law.

(b) In the event one or more members of a partnership or shareholders of a corporation shall have been convicted of a felony as described in paragraph (a) of this subdivision, the commissioner shall, in addition to his other powers, limit the existing operating certificate of such partnership or corporation so that it shall apply only to the remaining

partner or shareholders, as the case may be, provided that every such convicted person immediately and completely ceases and withdraws from participation in the management and operation of the hospital, and further provided that an application for approval of change of ownership or transfer of stock is filed without delay in accordance with the pertinent provisions of section twenty-eight hundred one-a of this chapter.

(c) With respect to the conviction of any such person of a class D or E felony, the commissioner shall make a determination before revoking, or limiting pursuant to paragraph (b), the operating certificate that such conviction was related to an activity or program subject to the regulations, supervision, or administration of the department or of the department of social services. With respect to the conviction of such person of a crime committed outside the state, the commissioner shall make a determination before revoking, or limiting pursuant to paragraph (b), the operating certificate that such crime, if committed within the state, would have been a class A, B or C felony or a felony related to an activity or program subject to the regulations, supervision, or administration of the department or of the department of social services or in violation of the public officers law. The commissioner shall notify the person convicted that such determination has been made and shall give such person thirty days to request a hearing pursuant to this subdivision.

(d) The commissioner shall not revoke, or limit pursuant to paragraph (b) of this subdivision, the operating certificate of any facility solely because of a conviction, more than ten years prior to the effective date of this paragraph, of any person of a felony unless the commissioner makes a determination that such conviction was related to an activity or program subject to the regulations, supervision, or administration of the department or of the department of social services. The commissioner shall not revoke, or limit pursuant to paragraph (b) of this subdivision, the operating certificate of any facility solely because of the conviction, more than ten years prior to the effective date of this paragraph, of any person of a crime outside the state unless the commissioner makes a determination that such crime, if committed within the state, would have been a felony related to an activity or program subject to the regulations, supervision, or

administration of the department or of the department of social services or in violation of the public officers law. The commissioner shall notify the person convicted that such determination has been made and shall give such person thirty days to request a hearing pursuant to this subdivision.

(e) Any hearing conducted hereunder shall be strictly limited to the issue of whether the determination of the commissioner is supported by the evidence. All such hearings shall be conducted as provided in paragraph (f) of this subdivision, and no hearing, revocation or limitation shall be stayed by the pendency of any appeal or other challenge to the conviction.

(f) The commissioner shall fix a time and place for the hearing. A copy of the notice and charges shall be served in person or mailed by registered or certified mail no less than ten days before the date fixed for the hearing. A written answer to the charges shall be filed with the department not less than two days prior to the hearing. No adjournment shall be granted in excess of forty-eight hours. The respondent may attend the hearing in person, with or without counsel, or be represented by counsel alone, but need not attend personally if unavailable because of incarceration, hospitalization or other reason. If no answer is filed with the department within the time limitation of this paragraph, a hearing shall be deemed to have been waived, and the commissioner shall issue an order based on the record before him.

(g) Nothing in this subdivision shall be construed to limit the authority of the public health council to revoke, limit or annul any approval of establishment.

6. (a) Notwithstanding the provisions of subdivisions two through four of this section, the commissioner shall suspend, limit, modify, or revoke a hospital operating certificate, after taking into consideration the total number of beds necessary to meet the public need, the availability of facilities or services such as preadmission, ambulatory, home care or other services which may serve as alternatives or substitutes for the whole or any part of any such hospital facility, and, in the case of modification, the level of care and the nature and type of services provided or required by all or some of the patients in or seeking admission to such hospital facility, and whether such level

of care is consistent with the operating certificate of the hospital, and after finding that suspending, limiting, modifying, or revoking the operating certificate of such facility would be within the public interest in order to conserve health resources by restricting the number of beds and/or the level of services to those which are actually needed.

(b) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular facility, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of the facility at least thirty days prior to making such a finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(c) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any facility, cause such facility and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action to revoke, suspend, limit, or modify the facility's operating certificate. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the facility or the appropriate health systems agency may request a public hearing to be held in the county in which the hospital is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(d) In the case of a modification of an operating certificate by the commissioner pursuant to paragraph (a) of this subdivision, the commissioner may not modify an operating certificate to reclassify beds previously authorized as hospital beds to domiciliary care beds or to increase the total number of beds authorized by such certificate, and, provided further that no patient in a hospital is to be removed as a result of the pendency or conclusion of a proceeding pursuant to this subdivision.

(e) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the

third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

(f) In determining whether there is a public need for any services or facilities as required by this subdivision, the commissioner shall consider the advice of the state health planning and development agency designated pursuant to the provisions of the national health planning and resources development act of nineteen hundred seventy-four and any amendments thereto and the state health plan developed thereunder.

*** § 2806-a. Temporary operator.** 1. For the purposes of this section:

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

(b) "established operator" shall mean the operator of an adult care facility, a general hospital or a diagnostic and treatment center that has been established and issued an operating certificate as such pursuant to this article;

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

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

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

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

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

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

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

2. (a) In the event that: (i) a facility seeks extraordinary financial assistance and the commissioner finds that the facility is experiencing serious financial instability that is jeopardizing existing or continued access to essential services within the community, or (ii) the commissioner finds that there are conditions within the facility that seriously endanger the life, health or safety of residents or patients, the commissioner may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility, or (iii) the commissioner finds that there has been an improper delegation of management authority by the governing authority or operator of a general hospital, the commissioner shall appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility. The appointment of the temporary operator shall be effectuated pursuant to this section and shall be in addition to any other remedies provided by law.

(b) The established operator of a facility may at any time request the commissioner to appoint a temporary operator. Upon receiving such a

request, the commissioner may, if he or she determines that such an action is necessary to restore or maintain the provision of quality care to the residents or patients or alleviate the facility's financial instability, enter into an agreement with the established operator for the appointment of a temporary operator to assume sole control and sole responsibility for the operations of that facility.

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

(b) The temporary operator shall use his or her best efforts to implement the work plan provided to the commissioner, if applicable, and to correct or eliminate any deficiencies or financial instability in the facility and to promote the quality and accessibility of health care services in the community served by the facility. Such correction or elimination of deficiencies or serious financial instability shall not include major alterations of the physical structure of the facility. During the term of his or her appointment, the temporary operator shall have the sole authority to direct the management of the facility in all aspects of operation and shall be afforded full access to the accounts and records of the facility. The temporary operator shall, during this period, operate the facility in such a manner as to promote safety and the quality and accessibility of health care services or residential care in the community served by the facility. The temporary operator shall have the power to let contracts therefor or incur expenses on

behalf of the facility, provided that where individual items of repairs, improvements or supplies exceed ten thousand dollars, the temporary operator shall obtain price quotations from at least three reputable sources. The temporary operator shall not be required to file any bond. No security interest in any real or personal property comprising the facility or contained within the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

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

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

(b) Upon the completion of the two ninety-day terms referenced in paragraph (a) of this subdivision,

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

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

(c) Within fourteen days prior to the termination of each term of the appointment of the temporary operator, the temporary operator shall submit to the commissioner and to the established operator a report describing:

(i) the actions taken during the appointment to address such deficiencies and financial instability,

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

(iii) recommended actions for the ongoing operation of the facility subsequent to the term of the temporary operator including recommendations regarding the proper management of the facility and ongoing agreements with individuals or entities with proper delegation of management authority; and

(iv) with respect to the first ninety-day term referenced in paragraph (a) of this subdivision, a plan for sustainable operation to avoid closure, or transformation of the facility which may include any option permissible under this chapter or the social services law and implementing regulations thereof. The report shall reflect best efforts to produce a full and complete accounting.

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

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

(b) Should the commissioner and the established operator be unable to establish a plan of correction pursuant to paragraph (a) of this subdivision, or should the established operator fail to respond to the commissioner's initial notification, a temporary operator shall be appointed as soon as is practicable and shall operate pursuant to the provisions of this section.

(c) The established operator shall be afforded an opportunity for an administrative hearing on the commissioner's determination to appoint a temporary operator. Such administrative hearing shall occur prior to such appointment, except that the hearing shall not be required prior to

the appointment of the temporary operator pursuant to clause (ii) of paragraph (a) of subdivision two of this section if the commissioner has determined that the immediate appointment of a temporary operator is necessary because public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any patient or resident of the facility. An administrative hearing as provided for under this paragraph shall begin no later than sixty days from the date of the notice to the established operator and shall not be extended without the consent of both parties. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to appoint a temporary operator is supported by substantial evidence. A copy of the decision shall be sent to the established operator.

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

7. No provision contained in this section shall be deemed to relieve the established operator or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or

omissions of the established operator or any other person prior to the appointment of any temporary operator hereunder; nor shall anything contained in this section be construed to suspend during the term of the appointment of the temporary operator any obligation of the established operator or any other person for the payment of taxes or other operating and maintenance expenses of the facility nor of the established operator or any other person for the payment of mortgages or liens.

8. The commissioner shall cause the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and the assembly health committees to be notified of the appointment of a temporary operator pursuant to paragraph (a) of subdivision two of this section upon such appointment. Such notification shall include, but not be limited to, the name of the established operator, the name of the appointed temporary operator and a description of the reasons for such appointment to the extent practicable under the circumstances and in the sole discretion of the commissioner.

* NB Repealed April 1, 2031

§ 2806-b. Residential health care facilities; revocation of operating certificate. Upon a determination by the commissioner that there exist operational deficiencies in a residential health care facility which show:

(a) a condition or conditions in substantial violation of the standards for health, safety or patient care established under federal or state law or regulations; or

(b) any other conditions dangerous to life, health or safety; or

(c) that there exists in the facility a pattern or practice of habitual violation of the standards of health, safety or patient care established under federal or state law or regulations, the commissioner shall take the actions prescribed by section twenty-eight hundred six of this article to revoke the operating certificate of the residential health care facility which was the subject of such finding and, where he deems it to be in the public interest, he may petition a court of competent jurisdiction to appoint a caretaker as defined in section twenty-eight hundred one of this article. The petition, the proceedings

and the procedures for the appointment of a caretaker shall be governed by the provisions of subdivision two of section twenty-eight hundred ten of this article, and the powers, duties and rights of a caretaker appointed pursuant to this section shall be the same as those authorized by such subdivision.

§ 2807. Hospital reimbursement provisions; generally. 1. Valid operating certificate requirement. No government agency and no corporation organized and operating in accordance with article forty-three of the insurance law and no health maintenance organization organized and operating in accordance with article forty-four of this chapter, shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service that has been determined by the commissioner of health to be unauthorized for payment under the medical assistance program pursuant to section twenty-eight hundred three of this article.

2. (a) Rate approvals. Payments for hospital service and health-related service made by government agencies or for services provided prior to January first, nineteen hundred ninety-seven by organizations operating in accordance with the provisions of article forty-four of this chapter shall be at rates approved by the state director of the budget in the case of government agencies and approved by the commissioner in the case of plans, organized and operating under the provisions of article forty-four of this chapter, under which such payments are made by agencies other than government agencies or corporations organized and operating in accordance with article forty-three of the insurance law. Payments for hospital service and health-related service by corporations organized and operating in accordance with article forty-three of the insurance law for services provided prior to January first, nineteen hundred ninety-seven shall be at rates approved by the commissioner of health.

(a-1) Notwithstanding any inconsistent provision of law, rates of payment by governmental agencies for the operating cost component of general hospital out-patient and emergency services, and for the operating cost component of treatment or diagnostic center services shall not require a certification by the commissioner that they are reasonably related to the costs of efficient production of such services nor that they are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

(b) During the period October first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-five and for each twelve month rate period commencing on October first thereafter, rates of payment by governmental agencies for the operating cost component of treatment or diagnostic center services shall be based on operating costs in the base year cost report adjusted by a trend factor determined in accordance with rules and regulations promulgated pursuant to paragraph (b) of subdivision two of section twenty-eight hundred three of this article; provided, however, that prior to such adjustment, allowable operating costs shall be established by the commissioner after taking into account the cost of services provided in facilities offering similar services and regional economic factors, plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures, incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the rate period commencing on October first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent rate period.

(c) Notwithstanding any other provision of law to the contrary, for a diagnostic and treatment center licensed pursuant to this article that provides, as its principal mission, services to individuals with developmental disabilities, the commissioner may fully or partially waive or modify recoupment of medical assistance payments based on retroactive changes to the applicable formula for capital costs for the period of September first, two thousand nine to December thirty-first, two thousand twelve.

* (e) Notwithstanding any inconsistent provisions of this subdivision or any other law, payments made by governmental agencies for ambulatory surgical services provided by a hospital, including general hospitals and diagnostic and treatment centers, during the period June first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine and the period January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety and every twelve month rate period thereafter shall be at case based rates of reimbursement established by the commissioner and approved by the state director of the budget. Ambulatory surgical services case based rates of payment shall be established prospectively and shall include operating costs and capital costs. Factors considered in establishing such case based rates shall include, but not be limited to: a classification of procedures with individual or combined rates established for each services classification; operating and capital costs of ambulatory surgical services efficiently and economically provided, considering regional economic factors, trended to the rate period; and the need for incentives to improve services and institute economies.

* NB Expired April 1, 2011

* (f) (i) During the period July first, nineteen hundred ninety through March thirty-first, nineteen hundred ninety-one, the rate periods during the period April first, nineteen hundred ninety-one through September thirtieth, nineteen hundred ninety-four and for each fiscal year period commencing on October first thereafter, comprehensive clinic rates of payment by governmental agencies established in accordance with paragraph (b) of this subdivision, applicable for services provided to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for voluntary non-profit or publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during a base year period established by regulation may include an allowance determined in accordance with this paragraph to reflect the needs of the diagnostic and treatment center for the financing of losses resulting from bad debt and the costs of charity care. Losses resulting from bad debt and the costs of charity care shall be determined by the

commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the diagnostic and treatment center and the availability of other financial support, including state and local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the diagnostic and treatment center. The bad debt and charity care allowance for a diagnostic and treatment center for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. A diagnostic and treatment center applying for a bad debt and charity care allowance pursuant to this paragraph shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of fifteen percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The commissioner may retrospectively reduce the bad debt and charity care allowance of a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the rate period in the delivery of comprehensive primary health care services to bad debt and charity care residents of the community.

(ii) The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible voluntary and nonprofit diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual aggregate amount of seven million three hundred thousand dollars. The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible publicly sponsored diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual

aggregate amount of seven million seven hundred thousand dollars; provided, however, that twenty percent of the amount of funds allocated for distribution to eligible publicly sponsored diagnostic and treatment centers shall be available for clinics operating under the auspices of the Health and Hospitals Corporation. Notwithstanding the foregoing and any other provision of this chapter municipalities which received state aid, pursuant to article two of the public health law and prior to the effective date of this chapter, in support of non-hospital based free-standing or local health department operated general medical clinics, shall receive a bad debt and charity care allowance of not less than the amount received in the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year for general medical clinics, plus the applicable local share for medical assistance expenditures under title XIX of the federal social security act. Funds to be distributed pursuant to this subparagraph shall be based on losses associated with the delivery of bad debt and charity care excluding the amount of such losses determined in accordance with subparagraph (ix) of this paragraph as the incremental loss basis for a supplemental allowance for a diagnostic and treatment center designated as a preferred primary care provider.

(iii) No diagnostic and treatment center may receive a bad debt and charity care allowance in accordance with this paragraph in an amount which exceeds its need for the financing of losses associated with the delivery of bad debt and charity care.

(iv) A nominal payment amount for the financing of losses associated with the delivery of bad debt and charity care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of bad debt and charity care for percentage increases in the relationship between base year period eligible bad debt and charity care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care	% of nominal financial
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clinic visits to total visits	loss coverage
up to 15%	50%

15 - 30%

75%

30%+

100%

If the sum of the nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers or for all eligible public diagnostic and treatment centers is less than the amount allocated for bad debt and charity care allowances pursuant to subparagraph (ii) or (ix) respectively of this paragraph for such diagnostic and treatment centers respectively, the nominal coverage percentages of base year period losses associated with the delivery of bad debt and charity care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit diagnostic and treatment centers or for public diagnostic and treatment centers in accordance with rules and regulations adopted by the council and approved by the commissioner.

(v) The bad debt and charity care allowance for each eligible voluntary non-profit diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for voluntary non-profit diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vi) The bad debt and charity care allowance for each eligible public diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for public diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vii) Diagnostic and treatment centers shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of bad debt and charity care provided. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable

diagnostic and treatment centers to fairly and accurately determine and report bad debt and charity care visits and the costs of bad debt and charity care. In order to be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must be in compliance with bad debt and charity care reporting requirements.

(viii) Of the funds allocated and distributed for bad debt and charity care allowances to eligible voluntary and non-profit diagnostic and treatment centers for a rate period in accordance with subparagraph (ii) of this paragraph, an annual aggregate amount not to exceed three million eight hundred thousand dollars within a rate period shall be paid by or on behalf of diagnostic and treatment centers into a primary care initiative pool established by the commissioner. Such funds shall be distributed to diagnostic and treatment centers in accordance with the provisions of subdivisions one through six of section twenty-eight hundred seven-b of this article.

(ix) During the period January first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-four and for each twelve month rate period commencing on October first thereafter, to the extent of funds available therefor, a diagnostic and treatment center which is approved as a preferred primary care provider pursuant to subdivision twelve of section twenty-eight hundred seven of this article and meets the requirements of this paragraph may be eligible for a supplemental allowance determined in accordance with this paragraph. The supplemental allowance shall be based on losses associated with the delivery of bad debt and charity care incurred by a preferred primary care provider to the extent such losses exceed any losses associated with the delivery of bad debt and charity care incurred for nineteen hundred ninety-three or, if later, the year immediately preceding the year in which the diagnostic and treatment center is first designated a preferred primary care provider.

(x) This paragraph shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowances determined in accordance with this paragraph.

(xi) Notwithstanding any inconsistent provision of this paragraph, adjustments to rates of payment for diagnostic and treatment centers

determined in accordance with subparagraphs (i) through (x) of this paragraph shall apply only for services provided on or before December thirty-first, nineteen hundred ninety-six.

* NB Expired December 31, 1996

(g)(i) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates of payment by governmental agencies for the operating cost component of general hospital outpatient services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided; provided, however, that the maximum payment for the operating cost component of outpatient services shall be sixty-seven dollars and fifty cents plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of the expenditures. The base year for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply. The commissioner may waive the maximum allowable payment and limitations on the rate of payment as prescribed herein to provide for the reimbursement of offering and arranging services eligible for ninety percent federal funds as set forth in section nineteen hundred three of the federal social security act, and to provide for the reimbursement of specialized services having separately identifiable costs and statistics, including but not limited to hemodialysis services and surgical services provided on an outpatient basis. Such waiver shall be granted only when the commissioner finds that the services are being provided efficiently and at minimum cost. The commissioner shall promptly promulgate rules and regulations necessary to identify such services. Among the criteria which the commissioner shall consider in the case of specialized services are whether the services require highly

specialized staff, equipment or facilities, thereby generating a cost that substantially exceeds that of more routine diagnostic or treatment services; whether the facility in which the services are provided is presently providing the services to the population in need; and, whether the services may be provided safely and effectively on an outpatient basis at a lower cost than through inpatient admission. In addition the commissioner shall provide for a waiver of the maximum allowable payment for those outpatient services medically necessary which include surgical procedures where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention. Where the commissioner waives the maximum allowable payment for any specified service he may, in accordance with the foregoing criteria and such other criteria as he deems appropriate, establish a maximum allowable payment for such specified service.

(ii) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates of payment by governmental agencies for the operating cost component of general hospital emergency services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided, and in addition shall include that portion of the reasonable incremental emergency service operating costs incurred by such hospital in excess of emergency service costs reported in the nineteen hundred eighty-eight cost report, after application of the trend factor, attributable to meeting additional quality of care standards for emergency services that became effective on or after January first, nineteen hundred eighty-nine; provided, however, that the maximum payment for the operating component shall be ninety-five dollars, provided further, however, that for the period January first, two thousand seven through December thirty-first, two thousand seven the maximum payment for the operating component shall be one hundred twenty-five dollars, and during the period January first, two thousand eight through December thirty-first, two thousand eight, the maximum payment for the operating component shall be one hundred forty dollars; and during the period January first, two thousand nine through December thirty-first, two thousand nine and for each calendar year thereafter, the maximum payment

for the operating component shall be one hundred fifty dollars. A capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for the major outpatient capital expenditures incurred subsequent to the report year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply prior to January first, two thousand seven.

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

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

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

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

(B) (1) Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall establish rates of reimbursement for pediatric diagnostic and treatment centers for all services provided on or after April first, two thousand twenty-four, to children eligible for medical assistance that reflect the costs necessary to provide care and services to children with medical fragility being treated at such pediatric diagnostic and treatment center.

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

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

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

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

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

* NB Repealed April 1, 2029

(h) Notwithstanding any inconsistent provisions of this subdivision or any other law, except as provided in section 43.02 of the mental hygiene law, the commissioner may, in accordance with rules and regulations adopted by the council and approved by the commissioner, establish rates of reimbursement for payments made by governmental agencies, subject to the approval of the state director of the budget, for services provided on an outpatient basis by a general hospital or diagnostic and treatment center designated as a preferred primary care provider pursuant to subdivision twelve of this section or providing specialty services including hemo and peritoneal dialysis, outpatient rehabilitative and psychiatric services, methadone maintenance, and other organized outpatient or clinic services which are structured to address extensive and complex medical needs for patients with chronic or infectious medical conditions based on factors other than those prescribed by paragraph (b) or subparagraph (i) of paragraph (g) of this subdivision or subdivision three of this section provided, however, that the use of such an alternative approach will not result in any increase to other rates of reimbursement established pursuant to this article. During the initial rate period such rates of payment for preferred primary care providers shall be at least equal to the average rate of payment per visit which would otherwise be provided pursuant to subparagraph (i) of paragraph (g) or paragraph (b) of this subdivision. Factors used to establish rates shall include a reasonable classification of medical procedures with individual or combined rates established for each service classification group which will be prospectively determined based upon an estimate of the costs of such outpatient services efficiently and economically provided by general hospitals and diagnostic and treatment centers, considering regional economic factors and the need for incentives to improve services and institute economies. Notwithstanding any inconsistent provisions of law, rates of payment by governmental agencies for outpatient services provided by a general hospital or diagnostic and treatment center, shall not require a certification by the commissioner that they are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

2-a. Notwithstanding any provision of which is inconsistent with or contrary to the structure established by this subdivision and subdivision thirty-three of section twenty-eight hundred seven-c of this article, and subject to the availability of federal financial participation, rates of payment by governmental agencies, established pursuant to this article, for general hospital outpatient services, general hospital emergency services, ambulatory surgical services provided by a hospital as defined by subdivision one of section twenty-eight hundred one of this article, and diagnostic and treatment center services, but excepting any facility whose reimbursement is governed by subdivision eight of this section or any payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program, shall be in accordance with the following:

(a)(i) for the period December first, two thousand eight through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates shall reflect the average Medicaid payment per claim, as

determined by the commissioner, for services provided by that facility for the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(v) This paragraph shall be effective the later of: (i) December first, two thousand eight, or (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate methodology established pursuant to subparagraph (i) of paragraph (a) of subdivision thirty-three of section twenty-eight hundred seven-c of this article.

(b) (i) for the period September first, two thousand nine through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for services provided by each diagnostic and treatment center and each free-standing ambulatory surgery center shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the

operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(c) for periods on and after December first, two thousand eight, such rates of payment for ambulatory surgical services provided by general hospitals shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision, provided however, that the capital cost component for such rates shall be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision.

(d) for periods on and after January first, two thousand nine, the operating cost component of such rates of payment for general hospital emergency services shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision and shall not reflect any maximum payment amount as otherwise provided for in subparagraph (ii) of paragraph (g) of subdivision two of this section.

(e) (i) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which

patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

If the commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the commissioner may utilize existing payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.

(ii) Notwithstanding this subdivision and any other contrary provision of law, the commissioner may incorporate within the payment methodology described in subparagraph (i) of this paragraph payment for services provided by facilities pursuant to licensure under the mental hygiene law, provided, however, that such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the commissioner, the commissioner of mental health, the commissioner of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities.

(iii) Regulations issued pursuant to this paragraph may incorporate quality related measures limiting or excluding reimbursement related to potentially preventable conditions and complications; provided however, such quality related measures shall not include any preventable conditions and complications not identified for Medicare nonpayment or limited payment.

* (iv) Effective April first, two thousand twenty, regulations issued pursuant to this paragraph for public general hospitals or public health systems, other than those operated by the state of New York or the state university of New York, located in a city having a population of one million or more shall reflect additional reimbursement for costs, to the extent permitted under 42 CFR 447.321(b)(1) and based on actual utilization of services. Such rate add-on shall be contingent upon

federal financial participation and approval, and subject to the terms of a binding memorandum of understanding executed between the department of health and the public general hospital or public health system receiving the rate add-on. If payment of such rate add-on is projected to cause Medicaid disbursements for such period to exceed the projected department of health Medicaid state funds in the enacted budget financial plan pursuant to subdivision three of section twenty-three of the state finance law, as determined by the director of the budget, or the memorandum of understanding is not executed or is breached, the commissioner, in consultation with the director of the budget, may either cancel or reduce payment of such rate add-on to achieve compliance with the enacted budget financial plan.

* NB Repealed March 31, 2029

(f)(i) The commissioner shall periodically measure the utilization and intensity of services provided to medical assistance recipients in ambulatory settings. Such analysis shall include, but not be limited to: measurement of the shift of surgical procedures from the inpatient hospital setting to the ambulatory setting including measurement of the impact of any such shift on quality of care and outcomes; changes in the utilization and intensity of services provided in the outpatient hospital department and in diagnostic and treatment centers; and the change in the utilization and intensity of services provided in the emergency department.

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, provided, however, that the commissioner may utilize existing payment methodologies or may promulgate regulations establishing alternative payment methodologies for one or more of the services specified in this subparagraph, effective for periods on and after March first, two thousand nine:

(A) services provided in accordance with the provisions of paragraphs (q), (r), and (ll) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) services provided by licensed social workers, licensed mental health counselors, and licensed marriage and family therapists, in accordance with licensing criteria set forth in applicable regulations; and

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven;

(E) services provided to pregnant women pursuant to paragraph (s) of subdivision two of section three hundred sixty-five-a of the social services law and, for periods on and after January first, two thousand ten, all other services provided pursuant to such paragraph (s) and services provided pursuant to paragraph (t) of subdivision two of section three hundred sixty-five-a of the social services law;

(F) wheelchair evaluation services and eyeglass dispensing services; and

(G) immunization services, effective for services rendered on and after June tenth, two thousand nine.

(f-1) Notwithstanding any inconsistent provision of this section or any other contrary provision of law, the commissioner may with the approval of the director of the budget, for periods prior to two thousand twelve, establish rates of payments for selected patient service categories that are based entirely upon the ambulatory patient groups methodology as authorized pursuant to paragraph (e) of this subdivision.

(g) for the purposes set forth in paragraphs (a) and (b) of this subdivision, rates described as in effect for the two thousand seven calendar year shall mean those rates which are in effect for that year on the date this subdivision becomes effective and such rates shall not thereafter, for the purposes set forth in such paragraphs (a) and (b),

be subject to further adjustment.

(h)(i) To the degree that rates of payment computed in accordance with paragraphs (a) and (d) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall remain subject to the provisions of subparagraphs (i) and (ii) of paragraph (g) of subdivision two of this section, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment computed pursuant to paragraph (a) of this subdivision which are based on average Medicaid payments per claim.

(ii) To the degree that rates of payment computed in accordance with paragraph (b) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall, for diagnostic and treatment centers, remain subject to the provisions of paragraph (b) of subdivision two of this section and shall, for free-standing ambulatory surgery centers, be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment which are based on average Medicaid payments per claim.

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, through March thirty-first, two thousand thirteen, and one hundred fifty-three million dollars for state fiscal year periods on and after April first, two thousand thirteen, provided, however, that for periods on and after April first, two thousand nine, such amounts may be adjusted to reflect

projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the two thousand seven calendar year to the applicable rate year, and provided further, however, that funds made available as a result of any such decreases may be utilized by the commissioner to increase capitation rates paid to Medicaid managed care plans and family health plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates as the commissioner determines necessary to facilitate access to quality ambulatory care services.

3. Commissioner rate certification, governmental payments. Prior to the approval of such rates, as provided in subdivision two of this section, the commissioner shall determine, and in the case of approvals by the state director of the budget, certify to such official that the proposed rate schedules for payments to hospitals for hospital and health-related services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research and those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified except for allowances authorized under section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article. In determining

and certifying to the state director of the budget rates of payment, including rates of payment for residential health care facilities, the commissioner shall take into consideration the different levels of care authorized to be provided in such hospital or health-related service and determine and certify distinct rates of payment for each such level of care. If the modification of an operating certificate of a hospital pursuant to subdivision six of section twenty-eight hundred six of this article requires the establishment of a rate for a level of service not previously provided in such hospital during the rate period existing at the time of such modification, a new rate period for that portion of the hospital reclassified as a result of such modification may be established upon sixty days' prior notice.

4. Commissioner rate certifications, payments pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law and the comprehensive motor vehicle insurance reparations act. For the rate years commencing January first, nineteen hundred eighty-six and January first, nineteen hundred eighty-seven the commissioner shall submit to the chairman of the workers' compensation board a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision two of section twenty-eight hundred seven-a of this article or as revised pursuant to subdivisions eleven and fourteen of section twenty-eight hundred seven-a of this article. Beginning with the rate period commencing January first, nineteen hundred eighty-eight the commissioner shall submit, and beginning with the rate period January first, nineteen hundred ninety-seven and certify, to the chairman of the workers' compensation board for an established rate period a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision one of section twenty-eight hundred seven-c of this article for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the comprehensive motor vehicle insurance reparations act and beginning with the rate year commencing January first, nineteen hundred ninety-one including payments pursuant to the volunteer ambulance workers' benefit law.

5. Audit authority. The commissioner shall make available to the

commissioner of social services, in a mutually satisfactory manner, all information necessary to conduct or have conducted, on a cost sharing basis among payors, an appropriate review or audit of the fiscal and statistical records of a hospital necessary to implement the provisions of this article.

6. Consideration of economic status in certain cases. Notwithstanding the provisions of this section, the commissioner, in determining and certifying rates of payment for services provided by a party to a contract entered into pursuant to the provisions of subdivision three of section twenty-eight hundred three of this article, shall take into consideration the economic status of the patients receiving such services.

7. Reimbursement rate promulgation. The commissioner shall notify each residential health care facility and health-related service of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least sixty days prior to the beginning of an established rate period for which the rate is to become effective and for general hospitals at least thirty days prior to the beginning of an established rate period for which the rate is to become effective. Notification shall be made only after approval of rate schedules by the state director of the budget. The sixty and thirty day notice provisions, herein, shall not apply to rates issued following judicial annulment or invalidation of any previously issued rates, or rates issued pursuant to changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of previously issued rates. Notwithstanding any provision of law to the contrary, nothing in this subdivision shall prohibit the recalculation and payment of rates, including both positive and negative adjustments, based on a reconciliation of amounts paid by residential health care facilities beginning April first, nineteen hundred ninety-seven for additional assessments or further additional assessments pursuant to section twenty-eight hundred seven-d of this article with the amounts originally recognized for reimbursement purposes.

7-a. Notwithstanding any inconsistent provision of law, with regard to a general hospital the provisions of subdivisions four and seven of this section and the provisions of section eighteen of chapter two of the laws of nineteen hundred eighty-eight relating to the requirement of prior notice and the time frames for notice, approval or certification of rates of payment, maximum rates of payment or maximum charges where not otherwise waived pursuant to law shall be applicable only to such rates of payment or maximum charges prospectively established for an annual rate period and such provisions shall not be applicable to a general hospital with regard to prospective adjustments or retrospective adjustments of established rates of payment or maximum charges for or during an annual rate period based on correction of errors or omissions of data or in computation, rate appeals, audits or other rate adjustments authorized by law or regulations adopted pursuant to section twenty-eight hundred three of this article.

7-b. Notification of diagnostic and treatment center approved rates.
(a) For rate periods or portions of rate periods beginning on or after October first, nineteen hundred ninety-four, the commissioner shall notify each diagnostic and treatment center of its approved rates of payment, which shall be used in the reimbursement for services provided to persons eligible for payments made by state governmental agencies at least thirty days prior to the beginning of the period for which such rates are to become effective.

(b) Notwithstanding any contrary provision of law, all diagnostic and treatment centers certified on or before September second, nineteen hundred ninety-seven shall, not later than September second, nineteen hundred ninety-seven, notify the commissioner whether they intend to maintain all books and records utilized by the diagnostic and treatment center for cost reporting and reimbursement purposes on a calendar year basis or, commencing on July first, nineteen hundred ninety-six, on a July first through June thirtieth basis, and shall thereafter maintain all books and records on such basis. All diagnostic and treatment centers certified after September second, nineteen hundred ninety-seven shall notify the commissioner at the time of certification whether they intend to maintain all books and records on a calendar year basis or on

or a July first through June thirtieth basis, and shall thereafter maintain all books and records on such a basis.

(c) The books and records maintained pursuant to paragraph (b) of this subdivision shall be utilized and made available to the commissioner in promulgating rates of payment for annual rate periods beginning on or after October first, nineteen hundred ninety-seven.

(d) Notwithstanding any provision of the law to the contrary, rates of payment established in accordance with paragraph (b) as amended, and paragraph (f) of subdivision two of this section for the rate period beginning April first, nineteen hundred ninety-three shall continue in effect through September thirtieth, nineteen hundred ninety-four, and applicable trend factors shall be applied to that portion of such rates of payment for the rate period which begins April first, nineteen hundred ninety-four.

8. Rates for federally qualified health centers and rural health centers. Notwithstanding section four of chapter eighty-one of the laws of nineteen hundred ninety-five, as amended by section twenty-seven of chapter one of the laws of nineteen hundred ninety-nine, and any other law, rule or regulation to the contrary, for periods on and after January first, two thousand one, rates of payment made by governmental agencies for services provided by diagnostic and treatment centers or general hospital outpatient clinics licensed under this article to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law which are also designated, in accordance with 42 USC § 1396a(aa), as federally qualified health centers or rural health centers shall be established in accordance with the following:

(a) For periods on and after January first, two thousand one, and prior to October first, two thousand one, such rates of payment shall be computed in accordance with paragraph (b) of subdivision two of this section, provided, however, that the operating and capital cost components of such rates and the applicable ceilings on allowable operating costs shall reflect an average of nineteen hundred ninety-nine and two thousand base year costs as reported to the department.

(b) For each twelve month period following September thirtieth, two thousand one, the operating cost component of such rates of payment

shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index as computed in accordance with the requirements of 42 USC § 1396a(aa)(3) and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

(c) Rates of payments to facilities which first qualify as federally qualified health centers or rural health centers on or after October first, two thousand shall be computed in accordance with the provisions of paragraph (b) of subdivision two of this section, provided, however, that the operating cost component of such rates shall reflect an average of the operating cost component of rates of payments issued to other facilities subject to this subdivision during the same rate period, located in the same geographic region and with a similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data as reported to the department. For each twelve month period following the rate period in which such facilities commence operation, the operating cost component of rates of payment for such facilities shall be computed in accordance with paragraph (b) of this subdivision. In calculating the operating cost component of such rates for facilities which first qualify as federally qualified health care centers on or after October first, two thousand, the counties comprising the geographic region known as downstate shall be the same as the counties comprising the downstate region for purposes of reimbursing diagnostic and treatment centers under ambulatory patient groups, which counties are specified in the regulations adopted by the commissioner implementing section 18 of part C of chapter fifty-eight of the laws of two thousand eight.

(d) Subject to receipt of all necessary federal approvals, rates of payment computed in accordance with this subdivision may be further adjusted in accordance with the provisions of subdivision seventeen of this section, provided, however, that such adjustments shall not be subject to trend adjustments as provided in paragraph (b) of this subdivision.

(e) Diagnostic and treatment centers eligible for rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision, which were, on December thirty-first, two thousand, receiving rates of payment

as preferred primary care providers computed pursuant to paragraph (h) of subdivision two of this section, may elect to continue to receive rates of payment computed in accordance with such paragraph (h), provided that in no event shall such rates of payment be less than the rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision.

(f) For any rate periods after March thirty-first, two thousand eight, subject to the availability of federal financial participation, the commissioner may prospectively adjust rates of payment for facilities otherwise subject to this subdivision to reflect alternative rate-setting methodologies, provided, however, that such alternative rate-setting methodologies must: (i) be authorized by applicable state law, (ii) be agreed to by the commissioner and each facility to which they are applied and (iii) in no event result in rates that are, in aggregate, less than the rates of payment otherwise provided for in this subdivision.

9. Payments under this section not to preclude other lawful payments. Any payments made under the authority of this section or section twenty-eight hundred seven-c of this article shall not preclude payments under any other section of law.

10. Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provisions of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development and/or continuation of limited pilot reimbursement programs to provide additional knowledge and experience in different types of reimbursement mechanisms for general hospitals.

* 11. Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provision of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development, implementation and operation of limited pilot reimbursement programs for general hospital outpatient services and diagnostic and treatment center services that would be prospective and associated to the resource use patterns in rendering ambulatory care

services.

* NB Expired April 1, 2020

12. (a) Notwithstanding any inconsistent provision of this article or any other law, for the purpose of improving access to and availability of comprehensive primary health care to persons receiving medical assistance pursuant to title eleven of article five of the social services law, the commissioner, upon application by a health care provider, may designate such provider as a preferred primary care provider in accordance with the provisions of this subdivision.

(b) Health care providers designated as preferred primary care providers pursuant to this subdivision shall meet such requirements as may be established by the commissioner in regulation, including, but not limited to:

(i) access by the medically indigent and medicaid eligible to ambulatory services;

(ii) provision, to the maximum extent practicable, of continuity of care;

(iii) arrangements for specialty physician care and necessary ancillary services;

(iv) reasonably accessible hours of operation;

(v) services which are accessible to medically underserved populations and communities including, to the maximum extent feasible, offering such services within the medically underserved community; and

(vi) participation in local social services district managed care programs established pursuant to section three hundred sixty-four-j of the social services law, provided that the commissioner, in consultation with the commissioner of social services, may exempt a health care provider from such participation for good cause. Good cause shall include but not be limited to geographic inaccessibility to managed care programs, inability to coordinate services of managed care programs, or that participation in the managed care program would significantly affect the provider's financial ability to provide services.

(c) For the purposes of this subdivision, a health care provider eligible to be designated as a preferred primary care provider shall mean a general hospital, a diagnostic and treatment center, a private physician, a nurse practitioner, a midwife, a professional corporation

or a group of physicians or nurse practitioners. The designation of any general hospital or a diagnostic and treatment center as a preferred primary care provider shall apply only to the specific site where the entity provides comprehensive primary health care services.

* 13. Subject to the availability of funds, the commissioner shall authorize health occupation development and workplace demonstration programs pursuant to the provisions of section two thousand eight hundred seven-h of this article for diagnostic and treatment centers, and the commissioner is hereby directed to make rate adjustments to cover the cost of such programs.

* NB Expired July 1, 2017

* 14. Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for diagnostic and treatment centers for services provided on or after April first, nineteen hundred ninety-five, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this subdivision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each diagnostic and treatment center with base year administrative and general costs exceeding the average.

* NB Expired March 31, 2011

15. Notwithstanding any inconsistent provision of law, including subdivision fourteen of this section, the facility-specific impact of eliminating the statewide cap on administrative and general costs, as imposed pursuant to subdivision fourteen of this section, for the period April first, nineteen hundred ninety-nine through June thirtieth, nineteen hundred ninety-nine pursuant to a chapter of the laws of nineteen hundred ninety-nine, shall be included in rates of payment for

facilities affected by such elimination for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine. In addition, rates for diagnostic and treatment centers for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine shall include, in the aggregate, the sum of fourteen million dollars which shall be added to rates of payment established in accordance with paragraphs (b) and (h) of subdivision two of this section based on an apportionment of such amount using a ratio of each individual provider's estimated medicaid expenditures to total estimated medicaid expenditures for diagnostic and treatment centers, as determined by the commissioner, for the October first, nineteen hundred ninety-nine through September thirtieth, two thousand rate period.

16. Notwithstanding any inconsistent provision of law, payment for drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law provided to persons receiving medical assistance pursuant to title eleven of article five of the social services law by any non-hospital based diagnostic and treatment center licensed under this article in existence on the effective date of this subdivision providing comprehensive primary medical care services and registered by the state board of pharmacy pursuant to section sixty-eight hundred eight of the education law shall be on a fee-for-service basis and shall not be included in any comprehensive clinic rate paid to such facility by governmental agencies established in accordance with paragraph (b) of subdivision two of this section.

17. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for free-standing diagnostic and treatment centers licensed pursuant to this article and which are: a "covered provider" as defined in subdivision one of section three hundred sixty-four-j-two of the social services law; or eligible for an allocation under paragraph (a-1) of subdivision two of section three hundred sixty-four-j-two of the social services

law; or which provides services to individuals with developmental disabilities as their principal mission, in accordance with paragraphs (b) and (c) of this subdivision for purposes of improving recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility in the following aggregate amounts for the following periods:

(i) for the period April first, two thousand two through December thirty-first, two thousand two, thirteen million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, thirteen million dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, thirteen million dollars;

(iv) for the period January first, two thousand five through December thirty-first, two thousand five, thirteen million dollars;

(v) for the period January first, two thousand six through December thirty-first, two thousand six, thirteen million dollars;

(vi) for the period January first, two thousand seven through June thirtieth, two thousand seven, six million five hundred thousand dollars;

(vii) for the period July first, two thousand seven through March thirty-first, two thousand eight, nine million seven hundred fifty thousand dollars; and

(viii) thirteen million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine;

(ix) thirteen million dollars for the period April first, two thousand nine through March thirty-first, two thousand ten; and

(x) thirteen million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven.

(b) Such adjustments to rates of payments shall be allocated proportionally based on each diagnostic and treatment center's total annual gross salary and fringe benefit costs, as reported in each such diagnostic and treatment center's nineteen hundred ninety-nine cost report as submitted to the department prior to November first, two thousand one, provided, however, that for periods on and after July first, two thousand seven, such adjustments to rates of payment shall be allocated proportionally, based on each such diagnostic and treatment center's total reported medicaid visits, as reported in each such

diagnostic and treatment center's two thousand four cost report as submitted to the department prior to January thirty-first, two thousand seven, to the total of such medicaid visits for all diagnostic and treatment centers.

(c) Rate adjustments made pursuant to this subdivision shall not be subject to subsequent adjustment or reconciliation.

(d) Diagnostic and treatment centers which have their rates adjusted pursuant to this subdivision shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

18. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the provisions of paragraph (c) of this subdivision and to the availability of federal financial participation, increase medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for eligible diagnostic and treatment centers by three percent for services provided on and after December first, two thousand two for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

(b) For the purposes of this subdivision, "eligible diagnostic and treatment center" shall mean a voluntary, not-for-profit diagnostic and treatment center licensed under this article that received medical assistance rates of payment reflecting assignment to limited primary care or drug free peer groups as established pursuant to applicable

rate-setting regulations and that provides primary health care services to a patient population primarily comprised of substance abuse patients and that is ineligible for an adjustment to medical assistance rates of payment under subdivision seventeen of this section.

(c) Diagnostic and treatment centers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

19. (a) Notwithstanding any provision of law, rule or regulation to the contrary and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall increase medical assistance rates of payment by three percent for services provided on and after December first, two thousand two by freestanding methadone maintenance service and program providers issued operating certificates pursuant to this article and section 32.09 of the mental hygiene law for the purposes of improving recruitment and retention of methadone maintenance workers.

(b) Freestanding methadone maintenance services and program providers which are eligible for rate adjustments pursuant to this subdivision and which are also eligible for rate adjustments pursuant to subdivision seventeen of this section, shall, on or before July first, two thousand two, submit, in a form and manner determined by the commissioner, amendments to designated sections of their AHCF-1 cost report segregating wages and fringe benefit costs associated with methadone

maintenance services from all other services for the purposes of determining awards made pursuant to subdivision seventeen of this section for rate periods ending in two thousand three and in two thousand four.

(c) Freestanding methadone maintenance service and program providers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such methadone maintenance service and program provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at such programs or any worker with direct patient care responsibility. The commissioner is authorized to audit each such methadone maintenance service and program provider to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

20. (a) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for Delivery System Reform Incentive Payments ("DSRIP") to such facilities. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the

payment of the DSRIP funds. The commissioner shall, to the maximum degree practicable, and to the extent permitted by the federal Centers for Medicare and Medicaid Services ("CMS"), ensure that the DSRIP program is implemented throughout the entire state.

(b) The commissioner shall establish an advisory panel to provide assistance with regard to the DSRIP program. The panel shall be charged with reviewing recommendations for DSRIP funding made by the state's contracted DSRIP assessor and advising the commissioner regarding the results of such review. Such panel shall also review applications under paragraph (b) of subdivision two of section twenty-eight hundred twenty-five of this article. Panel membership shall be comprised of individuals with significant health care system experience. Members may not be elected officials or employed by providers that would benefit from DSRIP funding, and must not have any conflict of interest that would prevent them from providing an impartial review of DSRIP assessor recommendations. The panel shall consist of members appointed by the commissioner and shall in addition consist of one member appointed by the majority leader of the New York state senate, and one member appointed by the speaker of the New York state assembly. The panel shall carry out the review of DSRIP recommendations in strict accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions. The panel shall submit its recommendations to the commissioner for final determination, in accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions. The commissioner may modify the requirements of this paragraph and paragraph (c) of this subdivision if such modifications are required by the federal CMS.

(c)(i) Project advisory committees. 1. Lead entities of systems established under the Medicaid delivery system reform incentive payment ("DSRIP") program shall establish a project advisory committee. The committee shall consider and advise the entity on matters concerning system operations, service delivery issues, elimination of health care disparities, measurement of project outcomes, the degree to which project goals are being reached and the development of any plans or programs. The entity may establish rules with respect to its project advisory committee.

(ii) The members of the committee shall be representatives of the

community, or geographic service areas, served by the system, including Medicaid consumers attributed to that system, and any other members required by the terms and conditions of the DSRIP program. The lead entity shall file with the commissioner, and from time to time update, an up-to-date list of the members of the committee, which shall be made available to the public by the department on its website.

(iii) Notwithstanding any inconsistent provision of law, no officer or employee of the state or of any civil division thereof, shall be deemed to have forfeited or shall forfeit his or her office or employment by reason of his or her acceptance of membership on a project advisory committee. No member of a project advisory committee shall receive compensation or allowance for services rendered on the committee, except, however, that members of a committee may be reimbursed by the entity or system for necessary expenses incurred in relation to service on a project advisory committee.

(d) For periods on and after April first, two thousand fourteen, the commissioner shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees with regard to the status of the DSRIP program. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include the most current information submitted by providers to the state and the federal CMS. The reports shall include:

- (i) analysis of progress made toward DSRIP goals;
- (ii) the impact on the state's health care delivery system;
- (iii) information on the number and types of providers who participate;
- (iv) plans and progress for monitoring provider compliance with requirements;
- (v) a status update on project milestone progress;
- (vi) information on project spending and budget;
- (vii) analysis of impact on Medicaid beneficiaries served;
- (viii) a summary of public engagement and public comments received;
- (ix) a description of DSRIP funding applications that were denied;
- (x) a description of all regulation waivers issued pursuant to paragraph (f) of this subdivision; and
- (xi) a summary of the statewide geographic distribution of funds.

(e) For periods on and after April first, two thousand fourteen the commissioner shall promptly make all DSRIP governing documents, including 1115 waiver standard terms and conditions, supporting attachments and detailed project descriptions, and all materials made available to the legislature pursuant to paragraph (d) of this subdivision, available on the department's website. The commissioner shall also provide a detailed overview on the department's website of the opportunities for public comment on the DSRIP program.

(f) Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow applicants under this subdivision and paragraph (a) of subdivision two of section twenty-eight hundred twenty-five of this article to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the authorizing commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be described, including each regulation waived and the project it relates to, in the report provided pursuant to paragraph (d) of this subdivision.

* 20-a. Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office of people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow providers that are involved in DSRIP projects or replication and scaling activities, as approved by the authorizing commissioner, to avoid duplication of requirements and to allow the efficient scaling and replication of DSRIP promising practices, as determined by the authorizing commissioner; provided however, that regulations pertaining to patient safety, patient autonomy, patient privacy, patient rights, due process, scope of practice, professional licensure, environmental protections, provider reimbursement

methodologies, or occupational standards and employee rights may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Any regulatory action under this subdivision shall be published on the applicable website of the authorizing commissioner and shall include a description of each waiver, including a citation of each regulation waived, and a description of the project of which such relief was granted.

* NB Expires April 1, 2028

21. (a) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for implementation of Medicaid Redesign Team initiatives. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the Medicaid Redesign Team initiatives funds.

(b) Applications by eligible applicants for Medicaid Redesign Team initiatives funded by monies made available pursuant to paragraph (a) of this subdivision shall be submitted for review to the advisory panel established pursuant to paragraph (b) of subdivision twenty of this section and such panel shall submit their recommendations to the commissioner for final determination. For periods on and after April first, two thousand fourteen, the commissioner shall provide a report on a quarterly basis to the majority leader of the New York state senate and to the speaker of the New York state assembly with regard to the status of such applications and approved projects. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include the most current information submitted by applicants to

the state. The reports shall be submitted in conjunction with and as a part of the reports submitted pursuant to paragraph (c) of subdivision twenty of this section and shall include:

- (i) analysis of progress made toward project goals;
- (ii) the impact on the state's health care delivery system;
- (iii) information on the number and types of providers who participate;
- (iv) plans and progress for monitoring provider compliance with requirements;
- (v) a status update on project milestone progress;
- (vi) information on project spending and budget;
- (vii) analysis of impact on Medicaid beneficiaries served;
- (viii) a summary of public engagement and public comments received;
- (ix) a description of applications that were denied;
- (x) a description of all regulation waivers issued pursuant to paragraph (e) of this subdivision; and
- (xi) a summary of the statewide geographic distribution of funds.

(c) The commissioner shall make all reports prepared pursuant to paragraph (b) of this subdivision and all supporting attachments and materials available on the department's website.

(d) Notwithstanding any inconsistent law to the contrary, and subject to federal financial participation, and subject to amounts appropriated for purposes herein, the department may distribute funds to make rate adjustments for health home providers as described in section three hundred sixty-five-l of the social services law for member engagement, staff training and retraining, health information technology implementation, joint governance technical assistance, and other such purposes as the commissioner, in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse services determines.

(e) Notwithstanding any provisions of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow applicants under this subdivision and paragraph (a) of subdivision two of section twenty-eight hundred twenty-five of this

article to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulation be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time period as the authorizing commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be described, including each regulation waived and the project it relates to, in the report provided pursuant to paragraph (b) of this subdivision.

§ 2807-a. General hospital nineteen hundred eighty-six and nineteen hundred eighty-seven inpatient rates and charges.

1. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven, the rates of payment to general hospitals for services provided to persons eligible for payments made by state governmental agencies and subscribers to article forty-three insurance law corporations and subscribers of organizations organized under article forty-four of this chapter (unless application is made to the commissioner under subdivision three of this section) shall be based on the reimbursable operating costs used in determining payments for services provided during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five. Such operating costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. In addition to the reimbursable operating costs identified in accordance with this subdivision, payment rates by governmental agencies and article forty-three insurance law corporations shall be adjusted each year to reflect:

(a) capital related expenses determined in accordance with subdivision seven of this section;

(b) additional financial needs or revenue requirements in accordance with subdivision eight of this section; and

(c) projection of reimbursable costs identified in accordance with

this subdivision by a trend factor established by the panel of economists as set forth in subdivision fourteen of this section.

2. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven, rates of payment pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law and the comprehensive motor vehicle insurance reparations act shall be established on the basis of one hundred twelve percent of the trended nineteen hundred eighty-one average operating reimbursable per diem inpatient cost of the hospital, plus the additions specified in subdivisions seven and eight of this section and such revisions that may be made pursuant to subdivisions eleven and fourteen of this section.

3. Nothing in this section shall prohibit the negotiation by health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, of agreements with general hospitals for rates of payment other than those provided herein. Such contracts shall require approval by the commissioner and must include provision for special benefit packages or arrangements for providing inpatient services to encourage patient management behavior that will minimize the length of patient stay, such as special admission arrangements, bed leasing or other inpatient capitation arrangements.

4. Hospital inpatient services reimbursement provided to patients who are not beneficiaries or subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, eligible for payments made by state governmental agencies, eligible for payments as beneficiaries of subchapter XVIII of the federal social security act, enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter, enrolled in a self-insured and self-administered group covered under the provisions of paragraph (b) of subdivision twelve of this section, or eligible for payments pursuant to the provisions of the workers' compensation law,

the volunteer firefighters' benefit law or the comprehensive motor vehicle insurance reparations act shall be at charges established by the hospital in accordance with subdivision twelve of this section.

5. Specialty hospitals shall receive reimbursement for general hospital inpatient services in accordance with the provisions of this section unless other reimbursement methodologies are adopted by the council and approved by the commissioner. In such event the allowances provided in subdivision eight of this section shall be included in certified and approved inpatient rates.

6. The establishment of separate rates of payment for patients who require different levels or types of care shall require a reallocation of costs to insure that costs are equitably allocated to service areas and appropriate rate adjustments are made.

7. Capital related expenses. Capital related inpatient expenses, including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on movable equipment if requested by the hospital, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-b of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to that article and article twenty-eight of this chapter), shall be included in rates established on a budget basis and subsequently reconciled to actual expenses through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital related inpatient expense generated by a capital expenditure which requires or required approval pursuant to this article, must have received such approval for the capital related expense to be included in the rates established. The submitted budget may include the capital related inpatient expenses for all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year or during the rate year provided all required approvals have been obtained.

The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The council shall adopt, with the approval of the commissioner, regulations to:

- (a) identify by type the eligible capital related inpatient expenses;
- (b) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;
- (c) provide authorization to adjust inpatient rates by advancing payment of depreciation as needed, in instances of capital debt related financial distress of a voluntary, non-profit general hospital; and
- (d) provide a methodology for the reimbursement treatment of sales.

8. Allowances. All rates established for the two years commencing on January first, nineteen hundred eighty-six in accordance with subdivisions one, two, three, four, five and six of this section shall include the allowances specified in paragraphs (a), (b), (c), (e) and (f) of this subdivision. The allowances shall be computed on the basis of the general hospitals' reimbursable inpatient costs after application of the trend factor. For the purposes of this subdivision and subdivisions sixteen and twenty-four of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(a) An allowance of one percent of the general hospitals' reimbursable inpatient costs computed in accordance with this section to be used at the discretion of hospital governing boards.

(b) For public general hospitals an additional allowance of up to two percent subject to the provisions of paragraph (d) of this subdivision.

(c) For voluntary non-profit and private proprietary general hospitals an additional allowance up to one percent subject to the provisions of paragraph (d) of this subdivision.

(d) The additional allowances in paragraphs (b) and (c) of this subdivision shall be available to general hospitals receiving approval

from the commissioner as to the acceptable use of the allowance which uses shall include but not be limited to retirement of short term non-capital debt, meeting costs related to bad debts and charity care not met by the distributions as specified in subdivisions sixteen and twenty-four of this section, offsetting reductions in anticipated revenue resulting from charge limits below those applicable to the particular hospital immediately prior to the enactment of subdivision twelve of this section, and needed improvement of current ratio. Allowances authorized by paragraphs (b) and (c) of this subdivision are not to be considered as a substitute for operational funds that are otherwise reimbursable or subject to appeal.

(e) A percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision fifteen of this section, and within a statewide determination of financial resources to be committed for this purpose. Regional needs shall be equal to the total of inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospitals from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. The regional amounts to be included in rates approved for the rate year commencing January first, nineteen hundred eighty-six and for the rate year commencing January first, nineteen hundred eighty-seven will be equal to the result of the application of the percentage of statewide need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, that can be met from available resources in regional pools, created in accordance with subdivision fifteen of this section computed without consideration of inpatient uncollectible amounts, to the regional need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, expressed in dollars plus the dollar amount resulting from the application of the ratio of major public general hospitals inpatient reimbursable costs within the region to total statewide general inpatient reimbursable cost (as computed on the basis of nineteen

hundred eighty-four financial and statistical reports and excluding costs related to services to beneficiaries of subchapter XVIII of the federal social security act) to the statewide resources committed for this purpose to regional pools computed without consideration of inpatient uncollectible amounts and the ratio of these total dollars to the total regional reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal social security act, after application of the trend factor. For each year of the two year period commencing on January first, nineteen hundred eighty-six the statewide amount to be available in regional pools for this purpose will equal four and one-half percent of the total hospital reimbursable inpatient cost, excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal social security act and inpatient uncollectible amounts, after application of the trend factor. The allocations of resources made available under this paragraph, as specified in subdivision sixteen of this section may be changed only as follows: An annual review shall be conducted pursuant to rules and regulations adopted by the council and approved by the commissioner with respect to bad debt and charity care need within each article forty-three insurance law region or such other regions as are adopted pursuant to subdivision fifteen of this section. If within such a region there is a definitive finding as a result of such review that there has been a change in the proportional amounts of bad debts and charity care provided by (i) major public general hospitals and (ii) voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, the allocation of resources made available under this paragraph shall be adjusted pursuant to the rules and regulations adopted pursuant to this paragraph so as to reflect this change.

(f) An additional allowance of fifty-eight hundredths of one percent shall be included in each rate established for each voluntary non-profit and private proprietary general hospital to be returned to a regional pool and distributed in accordance with paragraph (b) of subdivision sixteen of this section.

10. Special provisions for payments by governmental agencies. In the event that the allowances specified in subdivision eight of this section

are not approved by the federal government for federal financial participation in payments made for beneficiaries eligible for medical assistance under subchapter XIX of the federal social security act, rates of payment by governmental agencies for the operating cost component of general hospital inpatient services shall be based on the reimbursable operating costs used in determining payments for services provided during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five, including the annualized cost impact of rate revisions or adjustments made with respect to such services, projected by a trend factor determined in accordance with subdivision fourteen of this section, and adjusted by a base period adjustment factor to reflect the difference between the actual regional increase in inpatient general hospital operating cost for those regions as established pursuant to subdivision fifteen of this section between cost reporting periods for nineteen hundred eighty-one and nineteen hundred eighty-four and the trend factors developed to project costs for such period, provided, however, such base period adjustment factor shall not exceed an amount equal to the percentage allowances calculated in accordance with paragraphs (a), (b), (c), (e) and (f) of subdivision eight of this section. The commissioner shall assess all general hospitals within a region an amount equal to the regional allowance percentage as determined in accordance with paragraph (e) of subdivision eight of this section applied to actual inpatient revenues received from providing inpatient services to persons eligible for payments from state governmental agencies excluding inpatient revenues related to services provided to beneficiaries of subchapter XVIII of the federal social security act. The commissioner shall also assess an additional fifty-eight hundredths of one percent of actual inpatient revenues received by voluntary non-profit and private proprietary general hospitals for services provided to persons eligible for payments made by state governmental agencies excluding inpatient revenues related to services provided to beneficiaries of subchapter XVIII of the federal social security act. Such assessments shall be returned to regional pools in accordance with the methodology contained in subdivision fifteen of this section and distributed in accordance with the provisions of subdivision sixteen of this section.

11. Adjustments. (a) For the period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-seven, the commissioner shall on his own initiative, or on the basis of a request from a general hospital, adjust an established rate to reflect:

(i) the reduction of costs related to the elimination of a general hospital inpatient service in instances where the costs of such service were included in the rate established; and

(ii) the correction of errors or omissions of data or in computation.

(b) General hospitals may request and the commissioner shall consider an adjustment to an established rate to reflect increased expenses or reconsideration of disallowed expenses based on:

(i) justification of all or a portion of expenses not included in the rate resulting from the cost analysis process contained in subparagraph (i) of paragraph (a) of this subdivision;

(ii) additional operational expenses related to approved construction or service changes;

(iii) the addition of costs related to a state requirement for additional services to be provided or additional costs to be incurred in meeting state and federal requirements;

(iv) additional expenses to permit a more efficient and economical method of delivering a service; and

(v) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established rate related to subparagraph (v) of paragraph (b) of this subdivision, the commissioner shall consider:

(i) the fiscal capability of the general hospital to finance such increases from its own resources;

(ii) the past history of the general hospital with respect to compensation increases and allowed compensation trend factors; and

(iii) the economy in the area in which the general hospital is located.

(d) The commissioner shall adjust a prospectively established inpatient rate on the basis of subsequent data that demonstrates a significant cost influencing change in patient mix or volume of service. Such adjustments shall be based on rules and regulations adopted by the

council and approved by the commissioner. Such rules and regulations for a volume adjustment shall take into consideration only volume changes to other than beneficiaries of subchapter XVIII of the federal social security act.

(e) All appeals shall be submitted to the commissioner, who may submit a copy of the appeal to interested parties for the purpose of providing an opportunity for comment within a specified time period.

(f) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the rate is effective provided that all information necessary to determine whether an adjustment is justified is submitted by the facility prior to May first of such year. In the event such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

(g) The commissioner shall consider an adjustment to a hospital's reported base year costs in instances where it is demonstrated that recurring costs resulting from multi-year commitments beginning late in a base year should be calculated on an annual basis in establishing a rate in order to avoid a significant inequity. In making such an adjustment the commissioner shall consider the offset of non-recurring base year costs.

12. Hospital charge schedules. (a) Effective for the year commencing January first, nineteen hundred eighty-six and thereafter each general hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall establish gross inpatient charges such that the payment rate to be made on behalf of subscribers of article forty-three insurance law plans, adjusted for uncovered services shall be at a discount which shall not exceed twelve percent of the gross charge rate billed to or on behalf of charge paying patients. For general hospitals subject to the provisions of paragraphs (a) and (b) of subdivision twenty-one of this section, the costs (including all allowances specified in subdivision eight of this section) of services provided to charge paying patients shall not exceed a twelve percent

discount from the gross charge rate billed to or on behalf of charge paying patients. In the event that a hospital's gross inpatient charges exceed the maximum inpatient charges computed in accordance with the gross charge determination formula prescribed by the commissioner, direct repayment or adjustment of subsequent charges for inpatient services shall be effectuated in accordance with regulations adopted by the council and approved by the commissioner.

(b) For the period January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-seven, negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred eighty-five may continue.

13. Working capital. General hospitals may include as a financing or working capital charge an addition of two percent of any valid claim not paid within thirty days of submission or determination of payor liability, whichever is later, and one percent per month thereafter. Revenues received from such financing or working capital charges shall not be considered as a cost offset or as part of the hospital's gross inpatient charges. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in a periodic interim payment system.

14. Trend factors. (a) The commissioner in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs as defined in subdivision one of this section, or, if effective, subdivision ten of this section. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner. Not later than September first of each year, the consultants shall provide

to the commissioner and the council, the methodology to be used to determine the trend factors for the subsequent twelve month period commencing January first. The commissioner shall monitor the actual price movement during this twelve month period of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants, and shall implement, semi-annually, the recommendations of the consultants for adjustments to the trend factor, provided, however, that adjustments, except for the final adjustment of the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates differing by more than one-half of one percent from that which was previously determined.

15. Regional and statewide pools, general. Funds will be made available in regional pools for regional distributions through the submissions by general hospitals of the allowances included in rates and charges in accordance with paragraphs (e) and (f) of subdivision eight of this section and, if effective, the amount of the assessment in accordance with subdivision ten of this section. Funds will be made available for distribution from a statewide pool in accordance with the assessments authorized in subdivision twenty-three of this section. The regions are established as the article forty-three insurance plan regions, with the exception that the southern sixteen counties shall be divided into three regions for the purposes of subdivisions eight and sixteen of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties, and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. Such regions shall be the same regions established and in effect January first, nineteen hundred eighty-five. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur. The commissioner is authorized to contract with the article forty-three insurance law plans to receive funds for the pools and distribute such funds. In the event contracts with the article forty-three insurance law plans are effectuated, the

commissioner shall conduct annual audits of the receipt and distribution of the pooled funds. In order for general hospitals to participate in the distribution of funds from the pools the general hospital must implement collection policies and procedures approved by the commissioner.

16. Regional pools. Funds accumulated in regional pools, including income from invested funds, shall be distributed in accordance with the following methodology and sequence:

(a) Funds accumulated in regional pools, including income from invested funds, from the allowance specified in paragraph (e) of subdivision eight of this section and, if effective, the assessment against all general hospitals as authorized in subdivision ten of this section shall be distributed as follows:

(i) Each eligible major public general hospital as defined in subdivision eight of this section shall receive a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services to beneficiaries of subchapter XVIII of the federal social security act, developed on the basis of nineteen hundred eighty-four financial and statistical reports to the total of all regional pools.

(ii) Funds remaining in the regional pools after distribution in accordance with subparagraph (i) of this paragraph shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of need within the region as defined in paragraph (e) of subdivision eight of this section.

(b) Funds accumulated in regional pools, including income from invested funds, created by the allowance specified in paragraph (f) of subdivision eight of this section and, if effective, the fifty-eight hundredths of one percent assessment against voluntary non-profit and private proprietary general hospitals as authorized by subdivision ten of this section, shall be available for distribution by the commissioner in accordance with rules adopted by the council to assist in offsetting losses resulting from bad debts and the costs of charity care of voluntary non-profit and private proprietary general hospitals

experiencing severe fiscal hardship because of insufficient resources to finance such losses and costs. Such losses and costs may include losses and costs incurred prior to the year used in determining hospital need pursuant to paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with paragraph (a) of this subdivision and from the statewide pool in accordance with subparagraph (iii) of paragraph (a) of subdivision twenty-four of this section.

(c) Any balance in the portion of regional pools created by the allowance in paragraph (f) of subdivision eight of this section, and if effective, the fifty-eight hundredths of one percent assessment as authorized by subdivision ten of this section, including income from invested funds, after distribution in accordance with paragraph (b) of this subdivision shall be distributed to voluntary non-profit and private proprietary general hospitals within the region on a basis related to specific hospital need as defined in paragraph (e) of subdivision eight of this section.

20. Unit of service. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven the unit of service on which payment is made to general hospitals for inpatient services shall be the unit of service in effect during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five unless specifically provided otherwise in this section or modified pursuant to a subsequent chapter.

21. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this

chapter for patient services rendered shall not exceed the rates of payment approved by the superintendent of financial services or approved or certified by the commissioner, whichever is applicable and required by this section, for payments by such article forty-three insurance law corporations or article forty-four of this chapter organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article forty-three insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the schedule of charges established by such hospital for patient services in accordance with the provisions of subdivision twelve of this section.

(b) Any general hospital which has notified in writing an article forty-three insurance law corporation or a comprehensive health services plan prior to June first, nineteen hundred seventy-eight of its intention to terminate its contract with such corporation or plan in accordance with the terms of such contract, except a general hospital subject to the provisions of paragraph (a) of this subdivision may not charge a subscriber or beneficiary of a contract entered into pursuant to the provisions of article forty-three of the insurance law, or a member of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, after the effective date of termination of such contract, amounts in excess of the schedule of charges established by such hospital for patient services in accordance with the provisions of subdivision twelve of this section.

(c) No general hospital shall refuse to provide patient services to such subscribers or beneficiaries solely on the grounds of such subscription or membership.

22. Restitution authorization. In enforcing the provisions of subdivisions twelve and twenty-one of this section, the commissioner may, in addition to the penalties and injunctions set forth in section

twelve of this chapter, order that any general hospital provide restitution for any overpayments made by any party. Any hospital may request a formal hearing pursuant to the provisions of section twelve-a of this chapter in the event the hospital does not consent to any order of the commissioner hereunder. The commissioner may direct that such a hearing be held without any request by a hospital.

23. Bad debt and charity care assessments. The commissioner shall create a bad debt and charity care statewide pool through assessments which shall be charged to general hospitals to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care. Such assessments will be submitted to a statewide pool as designated by the commissioner and distributed on a monthly basis in accordance with subdivision twenty-four of this section. The bad debt and charity care assessments shall be:

(a) Three and eight-tenths percent aggregate assessment of each general hospital's gross revenue received for inpatient hospital service provided during the period July first, nineteen hundred eighty-six through December thirty-first nineteen hundred eighty-six composed of the following: (i) an assessment of three and eight hundredths percent to be allocated to a statewide bad debt and charity care account in the statewide pool and distributed in accordance with paragraph (a) of subdivision twenty-four of this section, (ii) an assessment of thirty-eight hundredths of one percent to be allocated to a statewide financially distressed hospital account in the statewide pool and distributed in accordance with paragraph (b) of subdivision twenty-four of this section, and (iii) an assessment of thirty-four hundredths of one percent to be allocated to a statewide transition account in the statewide pool and distributed in accordance with paragraph (c) of subdivision twenty-four of this section;

(b) One and nine-tenths percent aggregate assessment of each general hospital's gross revenue received for inpatient hospital service provided during the period January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven composed of the following: (i) an assessment of one and fifty-four hundredths percent to be allocated to a statewide bad debt and charity care account in the statewide pool and distributed in accordance with paragraph (a)

of subdivision twenty-four of this section, (ii) an assessment of nineteen hundredths of one percent to be allocated to a statewide financially distressed hospital account in the statewide pool and distributed in accordance with paragraph (b) of subdivision twenty-four of this section, and (iii) an assessment of seventeen hundredths of one percent to be allocated to a statewide transition account in the statewide pool and distributed in accordance with paragraph (c) of subdivision twenty-four of this section;

(c) Provided, however, there shall be no assessment against those voluntary non-profit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (b) of subdivision sixteen of this section and paragraph (b) of subdivision twenty-four of this section.

(d) For the purposes of this subdivision and subdivision twenty-four of this section, gross revenue received is defined as all monies received for or on account of inpatient hospital service, provided, however, that gross revenue received shall not include distributions from regional and statewide pools established in accordance with this section and shall not include the component of rates of payment related to the allowances provided in accordance with subdivision eight or, if effective, the base period adjustment factor provided in accordance with subdivision ten of this section.

24. Statewide pool distribution. (a) Funds accumulated in the statewide bad debt and charity care account in the statewide pool, including income from invested funds, shall be distributed in accordance with the following methodology:

(i) There shall be set aside within such account, from accumulated funds, from the total allocation to the statewide bad debt and charity care account of the assessment of three and eight hundredths percent of gross revenue received in accordance with subparagraph (i) of paragraph (a) of subdivision twenty-three of this section an amount equal to eighty-six hundredths of one percent of gross revenue received, as defined in paragraph (d) of subdivision twenty-three of this section, and from the total allocation to the statewide bad debt and charity care account of the assessment of one and fifty-four hundredths percent of gross revenue received in accordance with subparagraph (i) of paragraph

(b) of subdivision twenty-three of this section an amount equal to forty-three hundredths of one percent of gross revenue received, as defined in paragraph (d) of subdivision twenty-three of this section. Each eligible major public general hospital, as defined in subdivision eight of this section, shall receive from such funds a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide major public general hospital gross revenue received to such funds.

(ii) Any funds within the statewide bad debt and charity care account set aside for major public general hospitals and not distributed in accordance with subparagraph (i) of this paragraph shall be distributed in accordance with subparagraph (iii) of this paragraph.

(iii) Funds remaining in the statewide bad debt and charity care account, after allocation in accordance with subparagraph (i) of this paragraph, including funds available pursuant to subparagraph (ii) of this paragraph, and including income from invested funds, shall be distributed proportionately on a statewide basis to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of need as defined in paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with paragraph (a) of subdivision sixteen of this section.

(b) Funds accumulated in the statewide financially distressed general hospital account in the statewide pool, including income from invested funds, shall be distributed or retained in accordance with the following methodology:

(i) Funds in the statewide financially distressed general hospital account, including income from invested funds, shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance losses resulting from bad debts and the costs of charity care, and to meet reasonable and necessary costs related to securing financing of capital improvement projects for such general hospitals. Such losses and costs may include losses and costs

incurred prior to the year used in determining hospital need pursuant to paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with subdivision sixteen of this section and from the statewide bad debt and charity care account in accordance with subparagraph (iii) of paragraph (a) of this subdivision. The commissioner, in accordance with rules and regulations adopted by the council and approved by the commissioner, may allocate a portion of the accumulated funds for the purpose of securing financing of capital improvement projects for such general hospitals.

(ii) Any balance remaining in the statewide financially distressed general hospital account, including income from invested funds, not including that portion of accumulated funds allocated for the purpose of securing financing of capital improvement projects, after distribution in accordance with subparagraph (i) of this paragraph shall be distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on a basis related to need as defined in paragraph (e) of subdivision eight of this section.

(c) (i) Funds accumulated in the statewide transition account in the statewide pool, including income from invested funds, shall be distributed to voluntary non-profit, private proprietary and public general hospitals that have high percentages of gross revenue received from payors whose rates and maximum charges are determined in accordance with this section compared to total gross revenue received. For purposes of this subparagraph, major public general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended shall be considered on a consolidated basis. Rules for such distribution will be those adopted by the state hospital review and planning council and approved by the commissioner.

(ii) Any balance remaining in the statewide transition account, including income from invested funds, after distribution in accordance with subparagraph (i) of this paragraph shall be distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on a basis related to need as defined in paragraph (e) of subdivision eight of this section.

25. Maximum distributions. No general hospital may receive in total from the distributions made in accordance with paragraphs (a) and (c) of subdivision sixteen of this section and paragraph (a), subparagraph (ii) of paragraph (b) and subparagraph (ii) of paragraph (c) of subdivision twenty-four of this section an amount which exceeds its need for financing losses related to bad debts and the costs of charity care as defined in paragraph (e) of subdivision eight of this section.

26. Undistributed funds. Any funds, including income from invested funds, remaining in the statewide pool after distributions in accordance with paragraphs (a), (b) and (c) of subdivision twenty-four of this section shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, excluding major public general hospitals, on the basis of hospital specific assessments submitted to the pool.

27. Payment of assessments. Payments by or on behalf of general hospitals of funds due for the bad debt and charity care assessments pursuant to subdivision twenty-three of this section shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation. Upon receipt of notification from the commissioner, the comptroller or a fiscal intermediary designated by the director of the budget shall withhold from the amount of any payment to be made by the state to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment of the bad debt and charity care assessments. Upon withholding such amount, the comptroller or a designated fiscal intermediary shall pay the commissioner, or his designee, such amount withheld. Any general hospital in arrears resulting from failure to make a timely payment shall not be eligible for a distribution from the statewide pool in accordance with subdivision twenty-four of this section until such arrearage is satisfied.

28. Reimbursement rates. The assessments pursuant to subdivision twenty-three of this section shall not be an allowable cost in the determination of general hospital inpatient reimbursement rates in

accordance with this section and section twenty-eight hundred seven of this chapter.

§ 2807-aa. Nurse loan repayment program. 1.(a) Monies shall be made available, subject to appropriations, for purposes of loan repayment awards in accordance with the provisions of this section for registered professional nurses licensed to practice under section sixty-nine hundred five of the education law and licensed practical nurses licensed under section sixty-nine hundred six of the education law.

Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposals.

(i) Loan repayment awards made under this section shall be awarded to repay student loans of nurses who work in areas determined to be underserved areas in New York state and who agree to work in such areas for a period of three consecutive years. A nurse may be deemed to be practicing in an underserved area if they practice in a facility, physician's office, nurse practitioner's office, or physician assistant's office that primarily serves an underserved population, without regard to whether the population or the facility or office is located in an underserved area. For purposes of this section, "underserved areas" shall be located in New York state and shall include, but not be limited to, areas designated by the federal government as a health professional shortage area, a medically underserved area, or medically underserved population, non-profit diagnostic and treatment centers which primarily serve Medicaid eligible or uninsured patients, and other areas and populations as determined by the commissioner.

(ii) Loan repayment awards made under this section shall not exceed the total qualifying outstanding debt of the nurse from student loans to cover tuition and other related educational expenses, made by or

guaranteed by the federal or state government, or made by a lending or educational institution approved under title IV of the federal higher education act. Loan repayment awards shall be used solely to repay such outstanding debt.

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

(iv) In the event that a three-year commitment under this section is not fulfilled, the recipient shall be responsible for repayment of amounts paid which shall be calculated in accordance with the formula set forth in subdivision (b) of section two hundred fifty-four-o of title forty-two of the United States Code, as amended, or any regulations made thereunder.

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

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

3. In the event there are undistributed funds within amounts made available for distributions under this section, such funds shall be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for the purpose set forth in this section.

§ 2807-b. Outstanding payments and reports due under subdivision eighteen of section twenty-eight hundred seven-c, sections twenty-eight

hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article. 1. If there is a basis for estimating the amount of outstanding payments due in accordance with subdivision eighteen of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article, the commissioner shall bill applicable providers and payors for such payments, including any interest and penalties set forth in this article, no later than ninety days after each calendar quarter following enactment of this section.

2. If there is no basis for estimating the amount of outstanding payments due in accordance with subdivision eighteen of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article, the commissioner shall notify applicable providers and payors of outstanding reports and payments no later than ninety days after each calendar quarter following the effective date of this section. Such notice shall include information regarding any interest, penalties or other sanctions which may be implemented in accordance with this article.

§ 2807-c. General hospital inpatient reimbursement for annual rate periods beginning on or after January first, nineteen hundred eighty-eight. 1. Payor payments. Payments to general hospitals for inpatient hospital services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) shall be determined pursuant to this section. Payor payments shall be as follows unless an alternative reimbursement methodology is authorized in accordance with paragraph (e), (f), (g), (h) or (i) of subdivision four of this section.

* (a) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies for patients discharged prior to January first, two thousand and on and after January first, two thousand; or for patients discharged prior to January first, nineteen hundred

ninety-seven provided in accordance with policies written by corporations organized and operating in accordance with article forty-three of the insurance law, or payment by such a corporation on behalf of subscribers of a foreign corporation as described in paragraph (d) of subdivision twelve of this section, which provide for reimbursement on an expense incurred basis; or for patients discharged prior to January first, nineteen hundred ninety-seven provided to subscribers of organizations operating in accordance with the provisions of article forty-four of this chapter, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and shall include:

- (i) a reimbursable inpatient operating cost component determined in accordance with subdivision five of this section;

- (ii) capital related inpatient expenses determined in accordance with subdivision eight of this section;

- (iii) for patients discharged prior to January first, nineteen hundred ninety-seven (A) a bad debt and charity care allowance determined in accordance with subdivision fourteen of this section, (B) a general health care services allowance determined in accordance with subdivision fourteen-b of this section, and (C) a bad debt and charity care allowance for financially distressed hospitals determined in accordance with subdivision fourteen-c of this section;

- (iv) a projection of reimbursable inpatient operating costs to the rate year by the trend factor determined in accordance with subdivision ten of this section; and

- (v) adjustments for any modifications to the case payments determined in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section.

* NB Effective until December 31, 2029

- * (a) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies; or provided in accordance with policies written by corporations organized and operating in accordance with article forty-three of the insurance law, or payment by such a corporation on behalf of subscribers of a foreign corporation as described in paragraph (d) of subdivision twelve of this section, which

provide for reimbursement on an expense incurred basis; or provided to subscribers of organizations operating in accordance with the provisions of article forty-four of this chapter, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and shall include:

- (i) a reimbursable inpatient operating cost component determined in accordance with subdivision five of this section;

- (ii) capital related inpatient expenses determined in accordance with subdivision eight of this section;

- (iii) (A) a bad debt and charity care allowance determined in accordance with subdivision fourteen of this section, (B) a general health care services allowance determined in accordance with subdivision fourteen-b of this section, and (C) a bad debt and charity care allowance for financially distressed hospitals determined in accordance with subdivision fourteen-c of this section;

- (iv) a projection of reimbursable inpatient operating costs to the rate year by the trend factor determined in accordance with subdivision ten of this section; and

- (v) adjustments for any modifications to the case payments determined in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section.

* NB Effective December 31, 2029

- (a-1) Payments made by local governmental agencies to general hospitals for reimbursement of inpatient hospital services provided to incarcerated individuals of local correctional facilities as defined in subdivision sixteen of section two of the correction law shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision fourteen-f of this section.

* NB Effective until December 31, 2029

- (a-1) Payments made by local governmental agencies to general hospitals for reimbursement of inpatient hospital services provided to incarcerated individuals of local correctional facilities as defined in subdivision sixteen of section two of the correction law shall be at the rates of payment determined pursuant to this section for state governmental agencies.

* NB Effective December 31, 2029

* (a-2) (i) With the exception of those enrollees covered under a payment rate methodology agreement negotiated with a general hospital, payments for inpatient hospital services provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law made by organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law shall be the rates of payment that would be paid for such patients under the medical assistance program, (i) determined pursuant to this section, excluding adjustments pursuant to subdivision fourteen-f of this section, and (ii) excluding medical education costs that are reimbursed directly to the general hospital in accordance with paragraph (a-3) of this subdivision.

(ii) Effective July first, two thousand seven, with the exception of those enrollees covered under a payment rate methodology agreement negotiated with a general hospital, payment for inpatient hospital services provided to patients enrolled in the child health insurance program pursuant to title one-A of article twenty-five of this chapter made by organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law shall be the rates of payment that would be paid under the medical assistance program determined pursuant to this section, excluding adjustments pursuant to subdivision fourteen-f of this section.

* NB Expires December 31, 2029

* (a-3) Notwithstanding any inconsistent provision of law:

(i) the commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for general hospitals for the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand for payments under the medical assistance program pursuant to title eleven of article five of the social services law for persons eligible for medical assistance who are enrolled in health maintenance organizations and for payments under the family health plus program for persons enrolled in approved organizations

pursuant to title eleven-D of article five of the social services law based on the components of rates of payment established pursuant to this section for persons eligible for medical assistance who are not enrolled in health maintenance organizations for a general hospital for such rate period that reflect the estimated reimbursable costs of direct medical education expenses and indirect medical education expenses in the determination of:

(A) the hospital-specific average reimbursable inpatient operating cost per discharge pursuant to subdivision six of this section, and

(B) group category average inpatient reimbursable operating cost per discharge pursuant to subdivision seven of this section, and

(C) the operating cost component of rates of payment pursuant to paragraphs (f) and (k) of subdivision four of this section, and

(D) the operating cost component of rates of payment in accordance with paragraphs (e), (g) and (i) of subdivision four of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge; and

(E) notwithstanding clauses (A) through (D) of this subparagraph, for periods on and after December first, two thousand nine, the operating cost component of rates of payment subject to subdivision thirty-five of this section, and

(F) notwithstanding clauses (A) through (D) of this subparagraph, for periods on and after December first, two thousand nine, the operating cost component of rates of payment subject to paragraphs (e-1), (e-2) and (1) of subdivision four of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge; and

(ii) such rates of payment may be established by the commissioner on any appropriate payment basis, including a case mix adjusted per discharge basis.

* NB Expires December 31, 2029

* (b) For patients discharged prior to January first, nineteen hundred ninety-seven, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, with the

exception of those enrollees covered under a payment rate methodology agreement in accordance with the provisions of paragraph (a) of subdivision two of this section; or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis; or receiving inpatient hospital services pursuant to an out-of-plan benefits system authorized pursuant to section four thousand four hundred six of this chapter, except where such out-of-plan, inpatient hospital services are offered by an organization organized pursuant to the not-for-profit corporation law or which meets the qualifications of section 501(c) of the internal revenue code, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and equal to the case payments to general hospitals provided in accordance with paragraph (a) of this subdivision for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or, for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, increased by five percent. Funds received by a general hospital based on the payment differential applied pursuant to this paragraph shall be hospital funds for patient care purposes. Without due cause general hospitals shall not refuse to accept direct payments from a payor who would otherwise be eligible to reimburse hospitals for inpatient services on a case based payment per discharge in accordance with this subdivision.

(b-1) (i) For patients discharged on and after January first, nineteen hundred ninety-seven and prior to January first, two thousand and on and after January first, two thousand, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, and the comprehensive motor vehicle insurance reparations act shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision fourteen-f of this section and subdivision thirty-three of

this section, excluding such further reductions to such payments as are enacted as part of the state budget for the state fiscal year commencing April first, two thousand ten and excluding such further reductions to such payments as are enacted as part of the state budget for state fiscal years commencing on and after April first, two thousand eleven.

(ii) The provisions of paragraph (d) of subdivision eleven of this section shall continue to apply to such payors for payments determined pursuant to this paragraph.

(b-2) A payor included in the payor categories specified in paragraph (a) or (b-1) of this subdivision shall not be provided the option of payment to a general hospital for inpatient services based on the lower of hospital charges or the case based payment per discharge determined in accordance with this section for a patient or apportioning the appropriate case based payment per discharge for a patient by excluding payment for a preexisting condition or acquired condition which has to be treated along with the reason for the admission or, except as may affect qualification for payments in accordance with paragraph (b) or (d) of subdivision four of this section, for days within the inlier stay determined to be medically unnecessary.

* NB Effective until December 31, 2029

* (b) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, with the exception of those enrollees covered under a payment rate methodology agreement in accordance with the provisions of paragraph (a) of subdivision two of this section; or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis; or receiving inpatient hospital services pursuant to an out-of-plan benefits system authorized pursuant to section four thousand four hundred six of this chapter, except where such out-of-plan, inpatient hospital services are offered by an organization organized pursuant to the not-for-profit corporation law or which meets the qualifications of section 501 (c) of the internal revenue code, shall be case based payments per discharge, for each

diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and equal to the case payments to general hospitals provided in accordance with paragraph (a) of this subdivision for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or, for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, increased by five percent. Funds received by a general hospital based on the payment differential applied pursuant to this paragraph shall be hospital funds for patient care purposes. Without due cause general hospitals shall not refuse to accept direct payments from a payor who would otherwise be eligible to reimburse hospitals for inpatient services on a case based payment per discharge in accordance with this subdivision. A payor included in the payor categories specified in this paragraph or in paragraph (a) of this subdivision shall not be provided the option of payment to a general hospital for inpatient services based on the lower of hospital charges or the case based payment per discharge determined in accordance with this section for a patient or apportioning the appropriate case based payment per discharge for a patient by excluding payment for a preexisting condition or acquired condition which has to be treated along with the reason for the admission or, except as may affect qualification for payments in accordance with paragraph (b) or (d) of subdivision four of this section, for days within the inlier stay determined to be medically unnecessary.

* NB Effective December 31, 2029

* (c) Charge based payments. For patients discharged prior to January first, nineteen hundred ninety-seven, payments to general hospitals for reimbursement of inpatient hospital services provided to those for whom a case based payment per discharge system is not authorized by paragraph (a) or (b) of this subdivision, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, shall be on the basis of the hospital's charges; provided, however, for these patients the definition of a short stay patient pursuant to paragraph (d) of subdivision four of this section shall apply, and reimbursement to hospitals for such patients shall be at payments developed in

accordance with paragraph (d) of subdivision four of this section, increased by thirteen percent. The maximum amount to be charged to any charge paying patient for a case shall be one hundred twenty percent of the case based payment per discharge as determined under paragraph (b) of this subdivision for the diagnosis-related group with which the patient is identified. Each general hospital shall establish a charge schedule and inpatient charges from this schedule shall be applied uniformly for all inpatient charge based payments made in accordance with this section.

* NB Effective until December 31, 2029

* (c) Charge based payments. Payments to general hospitals for reimbursement of inpatient hospital services provided to those for whom a case based payment per discharge system is not authorized by paragraph (a) or (b) of this subdivision, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, shall be on the basis of the hospital's charges; provided, however, for these patients the definition of a short stay patient pursuant to paragraph (d) of subdivision four of this section shall apply, and reimbursement to hospitals for such patients shall be at payments developed in accordance with paragraph (d) of subdivision four of this section, increased by thirteen percent. The maximum amount to be charged to any charge paying patient for a case shall be one hundred twenty percent of the case based payment per discharge as determined under paragraph (b) of this subdivision for the diagnosis-related group with which the patient is identified. Each general hospital shall establish a charge schedule and inpatient charges from this schedule shall be applied uniformly for all inpatient charge based payments made in accordance with this section.

* NB Effective December 31, 2029

(d) The components of rates of payment calculated in accordance with this section related to inpatient operating costs shall be based on general hospital reimbursable inpatient operating costs used in determining payments for services pursuant to section twenty-eight hundred seven-a of this article during the rate period January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven (or for a distinct unit of a general hospital excluded from case based payments pursuant to paragraph (e) or (g) of

subdivision four of this section such distinct unit reimbursable inpatient operating costs), excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) in accordance with paragraph (g) of subdivision eleven of this section and adjusted to reflect the annualized cost impact of rate revisions or adjustments, including the volume adjustment and case mix adjustment for the nineteen hundred eighty-seven rate period, made with respect to such services, which shall be defined as a general hospital's or distinct unit's reimbursable inpatient operating cost base; a projection to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and an increase to reflect special additional inpatient operating costs determined and allocated in accordance with paragraph (e) of this subdivision.

(e) General hospital special additional inpatient operating costs shall be determined and allocated among general hospitals in accordance with subparagraphs (i), (iii) and (iv) of this paragraph. For purposes of computing group category average inpatient reimbursable operating costs in accordance with paragraph (a) of subdivision seven of this section and an equivalent cost component for general hospitals that are excluded from the case based payment per diagnosis-related group system in accordance with paragraph (e) or (g) of subdivision four of this section special additional inpatient operating costs shall include an additional increase determined and allocated among general hospitals in accordance with subparagraph (ii) of this paragraph.

(i) The total cost increases pursuant to this subparagraph for all general hospitals shall in the aggregate be one hundred thirty million dollars for the nineteen hundred eighty-eight rate period to reflect nineteen hundred eighty-five costs incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five, such cost increases to be projected from nineteen hundred eighty-eight to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals in accordance with the following methodology:

Five hundred dollars per bed shall be allocated to costs of each general hospital based on the total number of inpatient beds for which

the hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on January first, nineteen hundred eighty-eight.

A factor of one quarter of one percent of a general hospital's reimbursable inpatient operating cost base as defined in paragraph (d) of this subdivision, trended through nineteen hundred eighty-eight, shall be allocated to costs of general hospitals for technology advances and a further one quarter of one percent of such costs shall be allocated to costs of general hospitals for increased activities related to quality assurance and patient discharge planning.

The balance of one hundred thirty million dollars after deducting the dollar value of the per bed cost enhancement and the dollar value of the percentage cost enhancements shall be allocated to costs of general hospitals based on the ratio of each general hospital's nineteen hundred eighty-five cost incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five in the following discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to such balance: malpractice insurance costs, infectious and other waste disposal costs, water charges, direct medical education expenses, working capital interest costs of hospitals that qualified for distributions made in accordance with paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-a of this article, costs of distinct psychiatric units excluded from case based payments per diagnosis-related group, and ambulance costs. For purposes of this subparagraph, nineteen hundred eighty-five cost incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five shall be calculated for each such discrete area based on a general hospital's inpatient operating costs for the fiscal year ending in nineteen hundred eighty-five, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), for such discrete area in excess of the hospital's comparable component of reimbursable inpatient operating costs for its fiscal year ending in nineteen hundred eighty-one, after excluding inpatient operating costs

related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), trended through nineteen hundred eighty-five by the appropriate component of the trend factors and adjusted to reflect approved decreases or increases in inpatient operating costs resulting from all rate adjustments.

(ii) The total additional cost increases pursuant to this subparagraph for all general hospitals shall in the aggregate be forty million dollars for the nineteen hundred eighty-eight rate period, such additional cost increases to be projected from nineteen hundred eighty-eight to the rate period by the applicable trend factor, to be allocated among general hospitals in accordance with the following methodology:

The additional increase of forty million dollars shall be allocated to costs of general hospitals that are included in group categories established pursuant to paragraph (b) of subdivision seven of this section based on the ratio of the nineteen hundred eighty-eight intermediate group operating costs of each such general hospital, and to costs of general hospitals that are excluded from the case based payment per diagnosis-related group system in accordance with paragraph (e) or (g) of subdivision four of this section based on the ratio of the nineteen hundred eighty-eight intermediate operating costs of each such general hospital, to the total sum of such intermediate group operating costs and intermediate operating costs applied to the forty million dollars. For purposes of this subparagraph, intermediate group operating costs of a general hospital shall be calculated in accordance with rules and regulations adopted by the council and approved by the commissioner based on the reimbursable inpatient operating cost base determined in accordance with paragraph (d) of this subdivision of such general hospital; adjusted to exclude operating costs related to specialized hospital services for which an alternative reimbursement methodology is adopted pursuant to paragraph (e) or (g) or, if effective, (i) of subdivision four of this section; and trended to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and increased to reflect special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph; and adjusted to

exclude a factor for operating costs of patients who required an alternate level of care in accordance with paragraph (h) of subdivision four of this section; and adjusted to exclude the components of the trended reimbursable inpatient operating cost base related to education, physician, ambulance services and organ acquisition costs determined in accordance with subparagraphs (i), (iii) and (iv) of paragraph (c) of subdivision seven of this section and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph associated with cost increases in such costs. For purposes of this subparagraph, intermediate operating costs of a general hospital excluded from the case based payment per diagnosis-related group system shall be calculated in accordance with rules and regulations adopted by the council and approved by the commissioner based on the reimbursable inpatient operating cost base determined in accordance with paragraph (d) of this subdivision of such general hospital; trended to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and increased to reflect special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph; and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of subdivision four of this section; and adjusted to exclude the components of the trended reimbursable inpatient operating cost base related to education, physician, ambulance services and organ acquisition costs determined consistent with the provisions of subparagraphs (i), (iii) and (iv) of paragraph (c) of subdivision seven of this section and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph associated with cost increases in such costs.

(iii) Cost increases pursuant to this subparagraph shall be made for the nineteen hundred ninety-one rate period to reflect cost increases incurred in excess of the trend factor and not included in the costs used in determining payments in accordance with paragraph (d) of this subdivision and subparagraphs (i) and (ii) of this paragraph. Such costs shall in the aggregate be three hundred twenty-nine million dollars

exclusive of costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare). Such costs increases shall be projected from nineteen hundred ninety-one to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals, except those general hospitals whose base year for determining payments for services in such facilities is nineteen hundred eighty-seven, in accordance with the following methodology:

(A) Up to two hundred twenty-two million dollars shall be allocated for labor adjustments. If the total of the adjustments is less than two hundred twenty-two million dollars, then the adjustments shall be fully funded. If the total of the adjustments is more than two hundred twenty-two million dollars, then the adjustment specified in accordance with item (II) of this clause shall be funded at the lower of twenty percent of the total amount allocated for labor adjustments or its proportional share of the labor adjustments unless the labor adjustment specified in item (I) of this clause is less than eighty percent of the total amount allocated for labor adjustments in which case the adjustment specified in item (II) of this clause shall be equal to the difference between two hundred twenty-two million dollars and the total amount of the adjustment specified in item (I) of this clause.

(I) A portion of the amount allocated for labor adjustments shall be for labor cost increases related to registered nurses' salaries and fringes (twenty percent of salaries) and an add-on for the ripple effect on other health care professionals of at least thirty-five percent. Such adjustment shall cover both inpatient and outpatient cost incurred, based on costs reported in a survey conducted by the department for the period January first, nineteen hundred ninety through June thirtieth, nineteen hundred ninety on forms specified by the commissioner and received by the department no later than November first, nineteen hundred ninety, annualized, in excess of nineteen hundred eighty-five labor costs related to registered nurses' salaries and fringes trended to nineteen hundred ninety and the nineteen hundred eighty-eight statewide nurse salary adjustment trended to nineteen hundred ninety by the appropriate components of the trend factors adjusted to reflect the effect of the annualization of nineteen hundred ninety data and the result trended to nineteen hundred ninety-one and shall be based

exclusively on regional experience. Such regional adjustment shall not be less than zero. Each individual hospital within a region shall receive a portion of the regional adjustment equal to its share of the total inpatient and outpatient reimbursable operating costs for the region excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(II) A portion of the amount allocated for labor adjustments shall be for personnel costs other than those related to registered nurses' salaries and fringes and the ripple effect on other health care professionals. Such adjustment shall cover both inpatient and outpatient costs incurred, based on costs reported in a survey conducted by the department for the period January first, nineteen hundred ninety through June thirtieth, nineteen hundred ninety on forms specified by the commissioner and received by the department no later than November first, nineteen hundred ninety, annualized, in excess of nineteen hundred eighty-five personnel costs covered by this adjustment trended to nineteen hundred ninety and the annualized rate adjustments approved in nineteen hundred eighty-nine for personnel costs covered by this adjustment for increased hospital costs to meet additional state requirements that became effective July first, nineteen hundred eighty-nine trended to nineteen hundred ninety by the appropriate components of the trend factors adjusted to reflect the effect of the annualization of nineteen hundred ninety data and the result trended to nineteen hundred ninety-one and shall be based exclusively on regional data.

(III) In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allocation and adjustment specified in items (I) and (II) of this clause related to outpatient costs as a component of such payments is not approved by the federal government then such outpatient costs shall not be considered in calculating such adjustment.

(C) Thirty-three million dollars shall be allocated for technology advances and changes in medical practice. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which the general hospital is certified

pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety.

(D) Thirty-four million dollars shall be allocated to those general hospitals providing comprehensive health care to the communities they serve as determined by the commissioner pursuant to regulations approved by the council. Comprehensive health care includes providing and/or accommodating patients' health care needs at the appropriate levels and settings of care, and reaches outside of traditional inpatient services to outpatient and other services. Factors to be considered in deciding which general hospitals are providing comprehensive health care and the size of the adjustment shall include but not be limited to: clinic and emergency room volume compared to inpatient volume (measured using total volume and/or volume related to medicaid and medically indigent patients); number and type of clinic services offered; availability of services; whether the general hospital is an AIDS designated center, prenatal care assistance program provider, home health care provider, trauma center, burn center; whether the general hospital offers neonatal intensive care services, dialysis services, birthing center backup agreements, AIDS outpatient programs, specific mental health, drug and alcohol programs including outpatient and emergency services and those designated pursuant to section 9.39 of the mental hygiene law; and whether the general hospital's emergency room is designated as a 911 receiving hospital. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment specified in this clause as a component of such payments is not approved by the federal government because of the inclusion of outpatient services then such outpatient services shall not be considered in calculating such adjustment. If such exclusion results in the allocation for this adjustment not being spent, then any unspent portion shall be reallocated to further fund the adjustments specified in clauses (D) and (E) of this subparagraph in the same proportion as their original funding.

(E)(I) Twenty-six million dollars shall be allocated to the costs of general hospitals based on the ratio of each general hospital's nineteen hundred eighty-nine cost incurred in excess of the trend factor between

nineteen hundred eighty-five and nineteen hundred eighty-nine in the certain discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to the total funds under this allocation. Such discrete cost areas shall include but not be limited to: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast media, malpractice costs, water and sewer charges, ambulance costs and costs related to designation as a trauma center. For purposes of this clause, nineteen hundred eighty-nine cost incurred in excess of the trend factor between nineteen hundred eighty-five and nineteen hundred eighty-nine shall be calculated for each such discrete area based on a general hospital's inpatient operating costs for the fiscal year ending in nineteen hundred eighty-nine, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), for such discrete area in excess of the hospital's comparable component of reimbursable inpatient operating costs for its fiscal year ending in nineteen hundred eighty-five, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), trended through nineteen hundred eighty-nine by the appropriate component of the trend factors and adjusted to reflect approved decreases or increases in inpatient operating costs resulting from all rate adjustments.

(II) Any funds allocated under this clause and not distributed pursuant to item (I) of this clause shall be allocated for the following: to reimburse for a portion of the cost increases incurred above the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five for those discrete cost areas specified in the last paragraph of subparagraph (i) of paragraph (e) of this subdivision as added by chapter two of the laws of nineteen hundred eighty-eight and not reimbursed in accordance with such paragraph. Such funds shall be allocated to general hospitals in the same manner as specified in such paragraph.

(F) Seven million two hundred thousand dollars shall be allocated to account for the increase in the number of patients admitted through the emergency room and the high costs of treating such patients which has resulted in an increase in severity within diagnosis related groups.

Such funds shall be allocated to general hospitals based on the nineteen hundred eighty-nine hospital-specific data on increased admissions through the emergency room since nineteen hundred eighty-one, excluding those admissions related to providing services to beneficiaries of title XVIII of the federal social security act (medicare).

(G) Two hundred fifty dollars per bed shall be allocated to the costs of each general hospital having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient acute care services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, for recruiting and retaining health care personnel, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety.

(H) One million dollars shall be allocated to assist general hospitals involved in a merger, acquisition, or consolidation in meeting the costs associated with such merger, acquisition, or consolidation on or after January first, nineteen hundred ninety-one. The commissioner shall make rate adjustments for such allocations.

(I) Five hundred thousand dollars shall be allocated for a practitioner placement program to assist general hospitals in the placement of physicians and other health care practitioners to practice primary health care and/or dentistry in underserved areas, to serve the medically needy, and including services with affiliated community based providers. The commissioner shall make rate adjustments for such allocations. Notwithstanding any inconsistent provision of this subdivision, this clause shall not apply in rate periods commencing on or after January first, nineteen hundred ninety-four.

(iv) Cost increases pursuant to this subparagraph shall be made for the nineteen hundred ninety-four rate period to reflect cost increases incurred in excess of the trend factor and not included in the costs used in determining payments in accordance with paragraph (d) of this subdivision and subparagraphs (i), (ii) and (iii) of this paragraph. Such costs shall in the aggregate be one hundred seventy-three million dollars exclusive of costs related to services provided to beneficiaries

of title XVIII of the federal social security act (medicare). Such cost increases shall be projected from nineteen hundred ninety-four to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals in accordance with the following methodology:

(A) Forty-six million dollars shall be allocated to the costs of general hospitals for treating tuberculosis patients. Each general hospital shall receive a portion of this total equal to its share of the statewide total of inpatient tuberculosis discharges based on the most recent twelve month period for which data is available.

(B) Sixty-three million dollars shall be allocated for labor adjustments in accordance with the following methodology:

(I) Fifty-five million dollars shall be for labor cost increases incurred prior to June thirtieth, nineteen hundred ninety-three. Each general hospital shall receive a portion of this total equal to its share of the statewide total of inpatient and outpatient reimbursable operating costs based on nineteen hundred ninety data excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(II) Eight million dollars of the amount to be allocated for labor adjustments pursuant to this clause shall be distributed to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each individual hospital shall receive a portion of the eight million dollars equal to its share of the total inpatient and outpatient reimbursable operating costs based on nineteen hundred ninety data for all hospitals located in the above-referenced counties excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(C) Fifty-five million dollars shall be allocated to the costs of increased activities related to regulatory compliance, universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases, including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each

general hospital based on the total number of inpatient beds for which the general hospital is certified pursuant to the operating certificate issued for each general hospital in accordance with section twenty-eight hundred five of this article in effect on August twenty-fourth, nineteen hundred ninety-three.

(D) Three million dollars shall be allocated as follows:

(I) Two hundred fifty dollars per bed shall be allocated to the costs of each general hospital having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, in recognition of the unique costs incurred by these facilities in complying with state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on August twenty-fourth, nineteen hundred ninety-three.

(II) The remainder shall be allocated on a proportional basis to the costs of each general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, in recognition of the unique costs incurred by these facilities to provide hospital services in remote or sparsely populated areas, according to the following methodology:

(1) the net income, or the net loss expressed as a negative, as a proportion of the net patient revenue, of each such hospital, based on operating results for the nineteen hundred ninety and nineteen hundred ninety-one rate years, shall be computed and averaged, and expressed as a percentage;

(2) each such resulting percentage average shall be multiplied by each such hospital's number of inpatient beds for which such hospital is certified pursuant to the operating certificate issued for such hospital in accordance with section two thousand eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, and such resulting products for all such hospitals shall be summed, and such sum

shall be divided by the total of all such beds for all such hospitals, and the resulting quotient shall be the weighted average rural operating margin expressed as a percentage; and

(3) one percentage point shall be subtracted from each such hospital's average net operating margin, and the resulting difference shall be divided by the weighted average rural operating margin; and

(4) (a) if the quotient resulting from the computation in subitem three above is less than zero, then the absolute value of such quotient shall be multiplied by each such hospital's number of inpatient beds for which such hospital is certified pursuant to the operating certificate issued for such hospital in accordance with section two thousand eight hundred five of this chapter in effect on June thirtieth, nineteen hundred ninety, such product shall be multiplied by one hundred fifty dollars, and such resulting amount shall be such hospital's adjustment pursuant to this clause;

(b) if the quotient resulting from the computation in subitem three above is zero or greater, such hospital's adjustment pursuant to this clause shall be zero; and

(c) provided, however, that if the total of all such adjustments so computed exceeds the amount to be allocated in accordance with this item, each such hospital's adjustment shall be proportionately reduced.

(E) Three million dollars shall be allocated to assist general hospitals involved in a merger, acquisition, or consolidation in meeting the costs associated with such merger, acquisition, or consolidation on or after January first, nineteen hundred ninety-four. The commissioner shall make rate adjustments for such allocations.

(F) (I) One million five hundred thousand dollars shall be allocated for enhanced rates for general hospitals participating within a rural health network as defined in subdivision two of section twenty-nine hundred fifty-one of this chapter. Such rate enhancements shall be established only for inpatient services provided by such hospitals through the written rural health network agreement, where such services have been approved for enhanced rates by the commissioner. Notwithstanding any inconsistent provision of law, such enhanced rates shall be subject to the availability of federal financial participation pursuant to title XIX of the federal social security act in expenditures made for eligible patients, including pooling arrangements and volume

adjustments, provided, however that such enhanced rates shall not affect the calculation for any other general hospital of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section.

(II) One million five hundred thousand dollars shall be allocated for enhanced rates for general hospitals participating within a central services facility rural health network as defined in subdivision three of section twenty-nine hundred fifty-one of this chapter. Such rate enhancements shall be established only for inpatient services provided by such hospitals through the network operational plan, where such services have been approved for enhanced rates by the commissioner. Notwithstanding any inconsistent provision of law, such enhanced rates shall be subject to the availability of federal financial participation pursuant to title XIX of the federal social security act in expenditures made for eligible patients, including pooling arrangements and volume adjustments, provided, however that such enhanced rates shall not affect the calculation for any other general hospital of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section.

(f) The commissioner and the state director of the budget shall consider providing a supplementary increase to general hospital reimbursable inpatient operating costs for purposes of computing rates of payment for annual rate periods beginning on or after January first, nineteen hundred eighty-nine in accordance with this section for reasonable and necessary supplementary cost increases in general hospital operating costs for such rate period or periods based on increased minimum standards and procedures relating to general hospital operating certificates adopted by the council and approved by the commissioner or state initiatives related to recruitment or maintenance of an appropriate level of personnel providing professional services to patients. Any such supplementary increase shall be allocated to costs of general hospitals in accordance with rules and regulations adopted by the council and approved by the commissioner.

(g) Hospital discharges for purposes of computing case based payments per discharge pursuant to this section shall be based on the number of patient discharges during the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred

eighty-seven excluding discharges of beneficiaries of title XVIII of the federal social security act (medicare) and adjusted as provided in specific provisions of this section, or the number of such patient discharges during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven discharge data.

* (h) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five:

(i) rates of payment for patients eligible for payments made by state governmental agencies shall be reduced by the commissioner to reflect an exclusion from reimbursable inpatient operating costs commencing April first, nineteen hundred ninety-five of the special additional inpatient operating costs determined and allocated among general hospitals in accordance with clause (C) of subparagraph (iii) and clause (C) of subparagraph (iv) of paragraph (e) of this subdivision and the factor of one quarter of one percent of general hospitals' reimbursable inpatient operating cost base allocated to costs of general hospitals for technology advances in accordance with subparagraph (i) of paragraph (e) of this subdivision; and

(ii) general hospitals may not request and the commissioner shall not consider any pending or further appeals for an adjustment to rates of payment based on costs associated with technology advances and changes in medical practice and such adjustments to reimbursable inpatient operating costs pursuant to clause (C) of subparagraph (iv) of paragraph (e) of this subdivision.

(iii) Notwithstanding the foregoing, or any other provision of this section, the commissioner may establish pass through payments, or other appropriate methodologies, for the period ending December thirty-first, two thousand three for innovative medical device advances for which the federal centers for medicare and medicaid services adopts new codes to the hospital inpatient prospective payment system prior to the federal food and drug administration's approval of such medical device.

* NB Expired March 31, 2011

(i) For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state fiscal year thereafter through March thirty-first, two thousand nine,

and for the period April first, two thousand nine through November thirtieth, two thousand nine, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine the aggregate rate adjustments calculated pursuant to subparagraph (ii) of this paragraph shall not exceed four million dollars, and contingent upon the availability of federal financial participation:

(i) The commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for public hospitals other than non-state public hospitals located in a city with a population of more than one million persons, that meet the targeted medicaid discharge percentage in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "targeted medicaid discharge percentage" shall mean that at least seventeen and one-half percent of a public hospital's total discharges were patients eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six. Any hospital that meets the filing deadline shall have until June first, two thousand seven to submit revised and corrected data schedules in such institutional cost report which established eligibility for such adjusted rate.

(ii) The aggregate amount of rate adjustments calculated pursuant to this paragraph shall not exceed six million dollars for each rate period. Such amount shall be allocated proportionally based on the relative numbers of medicaid discharges among those public hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the current rate year.

(j) For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state fiscal year thereafter through March thirty-first, two thousand nine and for the period April first, two thousand nine through November thirtieth, two thousand nine, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine the aggregate rate adjustments calculated pursuant to subparagraph (ii) of this paragraph shall not exceed twenty-eight million dollars, and contingent upon the availability of federal financial participation:

(i) The commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for voluntary hospitals other than voluntary hospitals located in a city with a population of more than one million persons that meet the targeted medicaid discharge percentage in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "targeted Medicaid discharge percentage" shall mean between seventeen and one-half percent and thirty-five percent of a voluntary hospital's total discharges were patients eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six. Any hospital that meets the filing deadline shall have until June first, two thousand seven to submit revised and corrected data schedules in such institutional cost report which established eligibility for such adjusted rate.

(ii) The aggregate amount of rate adjustments calculated pursuant to this paragraph shall not exceed forty-two million dollars for each rate period. Such amount shall be allocated proportionally based on relative numbers of medicaid discharges among those voluntary hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be

included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the rate year.

(k) Subject to the availability of federal financial participation, the commissioner shall adjust inpatient rates of payment for non-public general hospitals located in a city with a population of more than one million persons for the following periods and in the following amounts in order to ensure meaningful access to the hospital's services and reasonable accommodation for all medicaid patients who require language assistance:

(i) for the period July first, two thousand seven through December thirty-first, two thousand seven, thirty-eight million dollars shall be allocated proportionally to such hospitals based on fifty percent of each such hospital's reported general clinic medicaid visits and fifty percent on each such hospital's reported medicaid inpatient discharges, as reported in each hospital's two thousand four institutional cost report, as submitted to the department prior to November first, two thousand six, to the total of all such general clinic visits reported by all such hospitals.

(ii) for the period April first, two thousand eight through March thirty-first, two thousand nine, and each state fiscal year thereafter through November thirtieth, two thousand nine, thirty-eight million dollars shall be allocated on an annualized basis for such purpose to such hospitals in accordance with the methodology set forth in subparagraph (i) of this paragraph, provided, however, that thirty percent of such funds shall be allocated proportionally, based on the number of foreign languages utilized by one or more percent of the residents in each hospital total service area population, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine, such allocation shall be reduced to twenty-five million three hundred thirty-three thousand dollars.

(l) Effective for periods on and after July first, two thousand seven through November thirtieth, two thousand nine:

(i) Subject to the availability of federal financial participation, the commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for general hospitals

located in the counties of Nassau and Suffolk in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "medicaid inpatient discharges" shall mean the total number of such general hospital's discharges where the patients were eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six.

(ii) The amount of rate adjustments calculated pursuant to this paragraph shall not exceed five million dollars in the aggregate annually. Such amount shall be allocated proportionally based on the relative numbers of medicaid discharges among those general hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the current rate year.

2. Special payment rate methodology agreements, negotiated rates. (a) Any payment rate methodology agreement negotiated between a self-insured and self-administered fund and a specific general hospital or its successor which was in effect on May first, nineteen hundred eighty-five shall be permitted to continue with such fund, or a self-insured and self-administered fund related in interest to such fund through merger, consolidation or corporate reorganization subsequent to May first, nineteen hundred eighty-five, as long as any revision to such methodology does not provide more of an economic advantage to the fund than the previous agreement. A general hospital which has any such agreement shall file with the commissioner information regarding each such agreement, as may be required by regulations adopted by the council and approved by the commissioner.

(b)(i) Nothing in this section shall prohibit the establishment of special payment rate methodologies in arrangements between general hospitals and health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, provided the commissioner has been notified of the proposed arrangement, has reviewed such proposed arrangement and has issued his written approval of the arrangement. The commissioner shall not approve such an arrangement if it would result in payments to a general hospital for inpatient services provided to subscribers of health maintenance organizations which in the aggregate are less than what otherwise would have been paid under the provisions of this section, unless the health maintenance organization demonstrates that such lower payments are justified because the arrangement will result in lower costs to the general hospital, and the payments approximate costs. Such arrangements may be approved by the commissioner to: integrate the medical delivery functions of the health maintenance organization with the medical delivery functions of the hospital, including but not limited to joint staffing arrangements or pre-admission testing arrangements; or integrate the method of payment and financial incentives to the hospital with the method of payment and financial incentives to physicians or other providers in the health maintenance organization; or integrate the method of payment and financial incentives to the hospital with the health maintenance organization, including, but not limited to, bed leasing or capitation payments. Notwithstanding any inconsistent provision of this section, for periods beginning on or after January first, nineteen hundred ninety-four, negotiated agreements between health maintenance organizations and general hospitals which were approved by the commissioner and which were in effect on December thirty-first, nineteen hundred ninety-three, may continue.

(ii) Notwithstanding any inconsistent provisions of this section, health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, having enrollees eligible for inpatient general hospital payments as beneficiaries of title XVIII of the federal social security act (medicare) shall reimburse general hospitals for inpatient services for these enrollees in accordance with the provisions

contained in title XVIII of the federal social security act (medicare).

(c) Special payment rate methodology agreements other than those permitted in accordance with the provisions of paragraphs (a) and (b) of this subdivision shall not be authorized, and no other arrangements with a general hospital for inpatient rates of payment other than those established in accordance with this section shall be negotiated.

* (d) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a), (b) and (c) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

* NB Expires December 31, 2029

3. Diagnosis-related groups and weights. (a) The commissioner shall establish as a basis for case classification for case based rates of payment the same system of diagnosis-related groups for classification of hospital discharges as established for purposes of reimbursement of inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period. However, the council may adopt rules and regulations, subject to the approval of the commissioner, to adjust such diagnosis-related groups or establish additional diagnosis-related groups to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate period, or to identify medically appropriate patterns of health resource use efficiently and economically provided. No such regulations, however, except those to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of title XVIII of the federal social security act (medicare) or for changes made to diagnosis-related groups for neonatal services and services to acquired immune deficiency syndrome (AIDS) patients shall apply to the rate period beginning January first, nineteen hundred eighty-eight. For subsequent rate periods regulations other than those to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of title XVIII of the federal social security act (medicare) may in addition apply to changes to the diagnosis-related groups for other services, including but not limited to, pediatric

services; provided, however, that psychiatric and rehabilitation services shall not be included.

Notwithstanding section one hundred twelve or one hundred seventy-four of the state finance law or any other law, rule or regulation to the contrary, the commissioner may contract with a vendor for nominal consideration to develop the specifications for the adjusted or additional diagnosis-related groups if the commissioner certifies to the comptroller that such contract is in the best interest of the health of the people of the state. Notwithstanding that such specifications shall be available pursuant to article six of the public officers law, such contract may provide that the specifications for such adjusted or additional diagnosis-related groups provided by the vendor shall be subject to copyright protection pursuant to federal copyright law.

(b) The methodology for assignment of patient discharges within diagnosis-related groups applicable for purposes of determining payments for discharges of beneficiaries of title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period, revised to reflect such adjustments as may be made to the diagnosis-related group classification system pursuant to paragraph (a) of this subdivision, shall be applied to assign specific patient discharges within the diagnosis-related groups established pursuant to paragraph (a) of this subdivision. The council may adopt rules and regulations, subject to the approval of the commissioner, to revise the methodology for the assignment of specific patient discharges within the diagnosis-related groups to reflect revisions to the methodology applicable for purposes of determining payments for discharges of beneficiaries of title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate period.

* (c) (i) The commissioner shall determine an appropriate weighting factor for each diagnosis-related group which reflects the relative general hospital resources used by all patients, other than beneficiaries of title XVIII of the federal social security act (medicare), with respect to discharges classified within that diagnosis-related group compared to discharges classified within other diagnosis-related groups. For rate periods during the period January

first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-five costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-nine costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand through December thirty-first, two thousand seven, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred ninety-two costs and statistics for a representative sample of general hospitals. For rate periods on and after January first, two thousand eight, the appropriate weighting factor for each diagnosis-related group shall be determined using two thousand four costs and statistics for a representative sample of general hospitals, and, further, the computation of the group average arithmetic inlier length-of-stays for each diagnostic related group, as otherwise determined in accordance with applicable regulations, shall utilize two thousand four data as reported to the department, and, be based on a representative sample of general hospitals, and further, the short-stay and long-stay length-of-stay trimpoints, as otherwise determined in accordance with applicable regulations, shall be computed utilizing two thousand four data as reported to the department and based on a representative sample of general hospitals. Provided however, that if the department does not release updated data and documentation described in subparagraph (iii) of this paragraph, the effective rate period shall be April 1, 2008. Discharges and costs related to the exceptions to case payment provided in accordance with paragraphs (e), (g) and (i) of subdivision four of this section shall be eliminated from the costs and statistics used in determining the appropriate weighting factors, while the cost factor related to the exception provided in paragraph (h) of subdivision four of this section shall be eliminated. The costs and statistics for the case payment modifications calculated pursuant to

paragraphs (a), (b), (c) and (d) of subdivision four of this section shall be eliminated in accordance with paragraph (c) of subdivision six of this section. Costs related to education, physician, ambulance services and organ acquisition identified consistent with the provisions of paragraph (c) of subdivision seven of this section and costs related to malpractice insurance shall also be eliminated. The council may adopt rules and regulations, subject to the approval of the commissioner, to prospectively adjust weighting factors determined in accordance with this paragraph to reflect changes in medical technology. After the commissioner issues rate certifications pursuant to subdivision four of section twenty-eight hundred seven of this article the commissioner shall expeditiously make available for inspection by general hospitals and payors the data, consistent with appropriate department procedures for the release and protection of confidential data, and the methodology utilized to determine the appropriate weighting factors.

(ii) Notwithstanding any contrary provision of law, the case mix adjustment to the operating component of per diem rates of payment paid to general hospitals or units of general hospitals that are exempt from case based payments, as determined in accordance with subdivision four of this section and as otherwise computed in accordance with applicable regulations, shall, for periods on and after January first, two thousand eight, be computed utilizing the diagnosis-related group classification system in effect for the rate year for inpatient case based medicaid rates of payment and the related per day cost weights calculated using two thousand four data as reported to the department and based on a representative sample of general hospitals. For rate periods on and after the two thousand eleven rate period, such case mix adjustment shall utilize the same base period data as determined in accordance with paragraph (e) of this subdivision.

(iii) The department shall, by no later than June first, two thousand seven, make available to hospital industry representatives relevant updated data and documentation that the department will utilize, in accordance with this paragraph, in developing appropriate service intensity weights for each diagnosis-related group for the two thousand eight rate period. The department will thereafter consult with hospital industry representatives in developing regulations to implement the utilization of such updated service intensity weight data applicable to

rate periods on and after two thousand eight. If it is deemed appropriate by the commissioner, in consultation with hospital industry representatives, such regulations may provide for the phase-in over a period of time of the application of such updated data in determining Medicaid rates on and after two thousand eight, provided, however, that the application of such updated data shall be fully reflected in such rates by no later than January first, two thousand ten.

(iv) By no later than December first, two thousand seven, the commissioner shall issue a report to the governor and the legislature describing the updated data utilization applicable, in accordance with the provisions of this paragraph, to periods on and after two thousand eight and setting forth the factors considered in developing it.

* NB Effective until December 31, 2029

* (c) The commissioner shall determine an appropriate weighting factor for each diagnosis-related group which reflects the relative general hospital resources used by all patients, other than beneficiaries of title XVIII of the federal social security act (medicare), with respect to discharges classified within that diagnosis-related group compared to discharges classified within other diagnosis-related groups. For rate periods during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-five costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-nine costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred ninety-two costs and statistics for a representative sample of general hospitals. Discharges and costs related to the exceptions to case payment provided in accordance with paragraphs (e), (g) and (i) of subdivision four of this section shall be eliminated from the costs and statistics used in determining the appropriate weighting factors, while

the cost factor related to the exception provided in paragraph (h) of subdivision four of this section shall be eliminated. The costs and statistics for the case payment modifications calculated pursuant to paragraphs (a), (b), (c) and (d) of subdivision four of this section shall be eliminated in accordance with paragraph (c) of subdivision six of this section. Costs related to education, physician, ambulance services and organ acquisition identified consistent with the provisions of paragraph (c) of subdivision seven of this section and costs related to malpractice insurance shall also be eliminated. The council may adopt rules and regulations, subject to the approval of the commissioner, to prospectively adjust weighting factors determined in accordance with this paragraph to reflect changes in medical technology. After the commissioner issues rate certifications pursuant to subdivision four of section twenty-eight hundred seven of this chapter the commissioner shall expeditiously make available for inspection by general hospitals and payors the data, consistent with appropriate department procedures for the release and protection of confidential data, and the methodology utilized to determine the appropriate weighting factors.

* NB Effective December 31, 2029

(d) The commissioner shall consult with technical advisory groups as necessary in establishing diagnosis-related groups and weights in accordance with paragraphs (a), (b) and (c) of this subdivision and in making adjustments in accordance with paragraphs (b) and (c) of subdivision six of this section.

(e) The appropriate weighting factor for each diagnosis-related group, the group average arithmetic inlier length-of-stays for each diagnosis-related group, and the short-stay and long-stay length-of-stay trimpoints shall, by no later than the two thousand eleven rate period, be based on reported costs and statistics from a representative sample of general hospitals from a base period no earlier than two thousand seven. Thereafter, the base period reported costs and statistics utilized for such purposes shall be updated no less frequently than every four years and the new base periods utilized shall be no more than four years prior to the applicable rate period.

3-a. Dispute resolution system. (a) * The commissioner shall establish, in accordance with rules and regulations adopted by the

council and approved by the commissioner, a payment dispute resolution system to resolve disputes between payors of inpatient hospital services and general hospitals for patients discharged on or after January first, nineteen hundred ninety-one and prior to January first, nineteen hundred ninety-seven. The commissioner shall designate the use of a uniform set of guidelines for determining the application of particular diagnosis-related group categories to particular patients which may include guidelines published by associations, universities or other organizations. The dispute resolution process shall apply to all payors of hospital services described in paragraphs (a), (b) and (c) of subdivision one of this section, including patients or payors which pay hospitals' charges or coinsurance, provided, however, such process shall not include payments made for persons eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) as a patients' primary payor or payments made pursuant to title eleven of article five of the social services law, provided that this exception shall not include payments for medical assistance participants in health maintenance organizations or prepaid health services plans. A payor of hospital services included in paragraph (a) of subdivision one of this section may serve as, or designate, the review agent for their subscribers, beneficiaries or enrolled members for an initial review and a reconsideration review but the final step in such dispute resolution process shall be an independent party unrelated to the payor which party shall be approved by the commissioner pursuant to this section.

* NB Effective until December 31, 2029

* The commissioner shall establish, in accordance with rules and regulations adopted by the council and approved by the commissioner, a payment dispute resolution system to resolve disputes between payors of inpatient hospital services and general hospitals for patients discharged on or after January first, nineteen hundred ninety-one. The commissioner shall designate the use of a uniform set of guidelines for determining the application of particular diagnosis-related group categories to particular patients which may include guidelines published by associations, universities or other organizations. The dispute resolution process shall apply to all payors of hospital services described in paragraphs (a), (b) and (c) of subdivision one of this

section, including patients or payors which pay hospitals' charges or coinsurance, provided, however, such process shall not include payments made for persons eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) as a patients' primary payor or payments made pursuant to title eleven of article five of the social services law, provided that this exception shall not include payments for medical assistance participants in health maintenance organizations or prepaid health services plans. A payor of hospital services included in paragraph (a) of subdivision one of this section may serve as, or designate, the review agent for their subscribers, beneficiaries or enrolled members for an initial review and a reconsideration review but the final step in such dispute resolution process shall be an independent party unrelated to the payor which party shall be approved by the commissioner pursuant to this section.

* NB Effective December 31, 2029

In the event a third party payor or patient desires to challenge the appropriateness of a bill for hospital services rendered by a general hospital for a particular patient, or in the event a general hospital desires to challenge the appropriateness of a payment by a third party payor on behalf of a particular patient, then either the hospital or the payor may submit the question to the dispute resolution process established pursuant to this subdivision. The disputes submitted for resolution may include the appropriateness of the application of a particular diagnosis-related group category, as described in subdivision three of this section, to a particular patient; the appropriate classification and payment of an inpatient stay as a modification of a case payment pursuant to paragraph (a), (b), (c), or (d) of subdivision four of this section, including whether payment for services should be, based on medical necessity or other reasons, made as a case payment or payment as a modification of a case payment; whether payment should appropriately be made pursuant to an alternative reimbursement methodology authorized in accordance with paragraph (e) or (h) of subdivision four of this section and the payment for such services; whether payment for services rendered by a general hospital should be appropriately, based on medical necessity or other reasons, made as payment for inpatient care or payment for outpatient care and the

payment for such services; or whether the hospital stay should be classified as a readmission as defined in accordance with regulations adopted pursuant to paragraph (l) of subdivision eleven of this section and the payment for such stay.

The dispute resolution system established shall provide for an initial review and a reconsideration review. The council shall adopt necessary rules and regulations, subject to the approval of the commissioner, including but not limited to those for determining the parties to a dispute resolution review and any reconsideration review; the procedures and time limits to initiate a dispute resolution review or any reconsideration review; the procedures for notification of all parties involved in the dispute upon initiation of a dispute resolution review or any reconsideration review; time limits for resolving disputes; the establishment of dispute resolution and reconsideration fees; and required documents to be submitted including the hospital bill in dispute, a copy of the patient medical record, or so much thereof as may be required, and a statement of issues including the basis for the dispute. During a dispute resolution review or any reconsideration review, a party may present documentation or evidence in support of its position regarding the appropriate diagnosis-related group to which the patient discharge should be assigned or the proper payment for the case. The commissioner shall approve a statewide utilization review organization or regional utilization review organization to conduct and determine such dispute resolution reviews including any reconsideration reviews in accordance with paragraph (b) of this subdivision. Every general hospital bill issued for a patient discharged on or after January first, nineteen hundred ninety-one other than for discharges of patients eligible for medical assistance pursuant to title eleven of article five of the social services law subject to case based payments determined pursuant to this section based on diagnosis-related group assigned or maximum hospital charges for a case determined pursuant to this section based on diagnosis-related group assigned shall include or be accompanied by a notice of the payment dispute resolution system; provided, however, that a general hospital issuing bills to a payor for twenty-five or more patients per year may send such notice to such payor on an annual basis. The form and content of such notice shall be

determined in accordance with rules and regulations adopted by the council and approved by the commissioner.

(b) The commissioner shall approve a statewide utilization review organization or regional utilization review organizations to conduct and determine dispute resolution reviews, including reconsideration reviews, pursuant to this subdivision. To be approved as a utilization review organization in accordance with this subdivision such organization must meet the following criteria: the organization shall employ or otherwise secure the services of adequate personnel, including medical personnel, qualified to review such disputes, the organization shall demonstrate the ability to render decisions in a timely manner, the organization shall agree to provide ready access by the commissioner to all data, records and information it collects and maintains concerning its review activities under this subdivision, the organization shall agree to provide to the commissioner such data, information and reports as the commissioner determines necessary to evaluate the review process provided pursuant to this subdivision, the organization shall provide assurances that review personnel shall not have a conflict of interest in conducting a review based on payor, hospital or professional affiliation, and the organization meets such other performance and efficiency criteria regarding the conduct of reviews pursuant to this subdivision established by the commissioner. The commissioner may withdraw approval of a utilization review organization where such organization fails to continue to meet approval criteria established pursuant to this paragraph. A utilization review organization approved pursuant to this paragraph shall be authorized to receive and review patient medical records and shall develop and implement appropriate procedures to maintain confidentiality of such patient medical records.

(c) Upon resolution of a payment dispute in accordance with this paragraph, the parties involved in the dispute shall be notified of the reason for the decision and the hospital bill in dispute shall be adjusted to reflect such resolution.

(d) The party initiating a payment dispute resolution review or any reconsideration review must submit to the utilization review organization a dispute resolution fee established to recover the costs related to the conduct of the initial dispute resolution reviews or a reconsideration review fee established to recover the costs related to

the conduct of such reconsideration reviews, except that for payors in paragraph (a) of subdivision one of this section which serve as or designate the review agent for their subscribers, beneficiaries, or enrolled members a fee shall be charged only for the final step in the dispute resolution process. Upon resolution of a payment dispute in accordance with this subdivision in favor of the payor, the amount due to the hospital by a payor based upon the hospital bill shall be reduced by the amount of any fee paid pursuant to this paragraph by such payor. Upon resolution of a payment dispute in accordance with this subdivision in favor of the general hospital, the amount due to the hospital based upon the hospital bill shall be increased by the amount of any fee paid pursuant to this paragraph by such general hospital.

(e) Nothing herein shall relieve the responsibilities of the payors as set forth in paragraphs (a), (b) and (c) of subdivision one of this section.

(f)(i) Whenever the amount of payment made by a payor to a general hospital is less than the amount of payment due determined by a utilization review organization in accordance with this subdivision, general hospitals in accordance with paragraph (d) of subdivision eleven of this section may include financing or working capital charges on such balance owed to the general hospital by a payor.

(ii) Whenever the amount of payment made by a payor to a general hospital is in excess of the amount of payment due determined by a utilization review organization in accordance with this subdivision, interest shall be due on such excess owed by the general hospital to a payor of two percent for the first thirty days and one percent per month thereafter from the date of payment of such excess amount. Interest shall not be applied to excess amounts owed to third party payors participating in an advance payment system.

(g) For payment amounts eligible for payment dispute resolution pursuant to this subdivision, a general hospital shall not bill a patient or pursue collection efforts against a patient for the difference between a hospital bill and the payment made on such bill by a payor within the payor categories specified in paragraph (a), (b) or (c) of subdivision one of this section, except for uncovered services by a payor, deductibles and coinsurance based on maximum hospital charges calculated based on the undisputed amount of the hospital bill, until

final decision of the utilization review organization. Nothing in this subdivision shall be construed to prohibit a general hospital from issuing an informational bill to a patient regarding such difference between the hospital bill and the payment made on such bill to advise the patient of the amount in dispute.

(h) The formal written decision of a utilization review organization approved by the commissioner to conduct and determine dispute resolution reviews in accordance with paragraph (b) of this subdivision upon a reconsideration review, or if there is no reconsideration review upon an initial review, or for a payor of hospital services included in paragraph (a) of subdivision one of this section which serves as or designates the review agent for their subscribers, beneficiaries or enrolled members upon the final step in the dispute resolution process as to the questions of the appropriateness of a bill for hospital services or the calculation of the proper payment for such hospital services shall be admissible in evidence at any subsequent trial upon the request of any party to the action. The decision shall not be binding upon the jury or, in a case tried without a jury, upon the trial court, but shall be considered prima facie evidence to establish the facts resolved by the utilization review organization.

4. Modifications and exceptions to case payment rates. Case based rates of payment shall be modified and per diem or other unit of service payments shall be provided, or exceptions shall be made to case payments, in accordance with rules and regulations adopted by the council and approved by the commissioner, in the following circumstances:

(a) where a case that is eligible for payment under the case based payment system is transferred between general hospitals, the receiving hospital shall be reimbursed its total case payment amount for the diagnosis-related group (including any payments made in accordance with this subdivision), and the transferring hospital shall receive reimbursement on a basis consistent with the methodology developed for the elimination of transfer patient costs in accordance with subparagraph (i) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on a per diem basis. The payment to a

transferring general hospital shall not exceed the case payment amount for the diagnosis-related group computed in accordance with this section;

(b) where the cost per case for a patient that does not qualify for payment pursuant to paragraph (a) or (d) of this subdivision is in excess of the basic case payment rate for the diagnosis-related group multiplied by two and the overall hospital-specific average cost per case multiplied by six, the payment to the general hospital in addition to the basic case payment rate will be one hundred percent, or such percentage as computed in accordance with subparagraph (ii) of paragraph (c) of subdivision six of this section, multiplied by the difference between the general hospital's cost for the case and the greater of the basic case payment rate for the diagnosis-related group multiplied by two or the overall hospital-specific cost per case multiplied by six. In determining whether a case qualifies for payment under this paragraph, prospective rate adjustments made in accordance with paragraph (c) of subdivision eleven of this section to reflect the retroactive impact of an adjustment on prior rates, shall be excluded. Where a case qualifies for payment pursuant to both this paragraph and paragraph (c) of this subdivision then payment shall be made in accordance with this paragraph if such payment exceeds that which would be made in accordance with paragraph (c) of this subdivision. The general hospital's costs per case shall be computed by adjusting the general hospital's actual charges for the case by the general hospital's inpatient cost to charge ratio;

(c) where a patient is identified as a long stay patient, payment to the general hospital in addition to the basic case payment rate shall be on a basis consistent with the methodology developed for the elimination of long stay patient costs in accordance with subparagraph (iii) of paragraph (c) of subdivision six of this section. Where a case qualifies for payment pursuant to both this paragraph and paragraph (b) of this subdivision then payment shall be made in accordance with paragraph (b) of this subdivision if such payment exceeds that which would be made in accordance with this paragraph. A long stay patient is defined as an inpatient whose hospital stay exceeds the long stay outlier threshold for the diagnosis-related group;

(d) where a patient is identified as a short stay patient, payment to the general hospital shall be on a basis consistent with the methodology

developed for the elimination of short stay patient costs in accordance with subparagraph (iv) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on a per diem basis. A short stay patient is defined as an inpatient discharged from the hospital on the same day of admission, or the day after admission except for those stays where the statewide mean length of stay for the diagnosis-related group is less than three days, or whose hospital stay is not greater than twenty percent of the statewide mean length of stay for the diagnosis-related group with which the patient is identified, excluding normal newborn cases and normal deliveries;

(e) in cases where a general hospital or distinct unit of a general hospital is not or would not have been reimbursed on a case based payment per diagnosis-related group for inpatient services provided on or before December thirty-first, two thousand one, to beneficiaries of title XVIII of the federal social security act (medicare), reimbursement shall be on a per diem basis computed for excluded general hospitals based on the hospital's reimbursable inpatient operating cost base, or for excluded distinct units of general hospitals based on the distinct unit's reimbursable inpatient operating cost base, determined in accordance with paragraph (d) of subdivision one of this section, projected to the applicable rate period by the trend factor determined in accordance with subdivision ten of this section, and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs, and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of this subdivision, and increased for excluded general hospitals to reflect the product of the group category percentage amount applicable for purposes of determining group category average inpatient reimbursable operating cost per discharge (price) in the rate period pursuant to paragraph (b) of subdivision five of this section for general hospitals reimbursed on a case based payment per diagnosis-related group applied to such excluded general hospital's additional cost increases determined in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section, and adjusted on a payor category basis to reflect allocation of malpractice insurance

costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section, for those patients included in the payor categories pursuant to the provisions of paragraph (a) or (b) of subdivision one of this section; provided, however, for those patients included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section payment shall be at the per diem payment to the hospital or distinct unit of the hospital for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or by five percent, as the case may be; provided further, however, for those general hospitals that are not reimbursed on a case-based payment per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) as a result of their designation by the secretary of health and human services as a comprehensive cancer hospital or as a result of their status as an acute care exempt children's hospital, the base year for determining payments for services in such facilities shall be nineteen hundred eighty-seven, provided, however, such hospitals shall be allowed adjustments in rates of payment to reflect costs incurred subsequent to nineteen hundred eighty-seven but not reflected in such base. Funds received by a general hospital based on the payment differential in accordance with paragraph (b) of subdivision one of this section applied pursuant to this paragraph shall be hospital funds for patient care purposes. For those patients not covered under the provisions of paragraph (a) or (b) of subdivision one of this section, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, payment shall be on the basis of the hospital's charge schedule, limited to one hundred twenty percent of the total per diem payment that would have been made if the patient were included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section. Rates of payment for excluded general hospitals and excluded distinct units of general hospitals for a rate period shall be increased on a per diem basis by additions and allowances specified in subparagraphs (ii) and (iii) of paragraph (a) of subdivision one of this section. In adopting regulations for purposes of determining rates of payment for psychiatric

services pursuant to this paragraph, the council and the commissioner shall consider the advice of the commissioner of mental health and may include case mix and other adjustments for such rates of payment. The commissioner of mental health shall study and report on alternative procedures for the development of rates of payment for inpatient psychiatric care. Such report shall be submitted to the governor, the legislature and the commissioner of health by January first, nineteen hundred ninety-three. Recommendations for alternative financing shall take into consideration methods to improve access to inpatient care for seriously mentally ill persons.

(e-1) Notwithstanding any inconsistent provision of paragraph (e) of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, per diem rates of payment by governmental agencies for a general hospital or a distinct unit of a general hospital for inpatient psychiatric services that would otherwise be subject to the provisions of paragraph (e) of this subdivision shall, with regard to days of service associated with admissions occurring on and after April first, two thousand ten, be in accordance with the following:

(i) For rate periods on or after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this paragraph. The commissioner may make such adjustments to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

Furthermore, the commissioner shall establish such rates in consultation with industry representatives to achieve an appropriate base year update to the operating cost components of rates of payment for services described in this paragraph and that takes into account

facility cost, mix of services, and patient specific conditions.

(ii) Rates of payment established pursuant to subparagraph (i) of this paragraph shall reflect an aggregate net statewide increase in reimbursement for such services of up to twenty-five million dollars on an annual basis.

(iii) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

(e-2) Notwithstanding any inconsistent provision of paragraph (e) of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, per diem rates of payment by governmental agencies for inpatient services provided by a general hospital or a distinct unit of a general hospital for services, as described below, that would otherwise be subject to the provisions of paragraph (e) of this subdivision, shall, with regard to days of service occurring on and after December first, two thousand nine, be in accord with the following:

(i) For physical medical rehabilitation services and for chemical dependency rehabilitation services, the operating cost component of such rates shall reflect the use of two thousand five operating costs for each respective category of services as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statute, provided, however, that such two thousand five reported operating costs, but not including reported direct medical education cost, shall, for rate-setting purposes, be held to a ceiling of one hundred ten percent of the average of such reported costs in the region in which the facility is located, as determined pursuant to clause (E) of subparagraph (iv) of paragraph (1) of this subdivision; and provided, further, that for physical medical rehabilitation services, the commissioner is authorized to make adjustments to such rates for the purposes of reimbursing pediatric ventilator services.

(ii) For services provided by rural hospitals designated as critical access hospitals in accordance with title XVIII of the federal social security act, the operating cost component of such rates shall reflect the use of two thousand five operating costs as reported by each

facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, provided, however, that such two thousand five reported operating costs shall, for rate-setting purposes, be held to a ceiling of one hundred ten percent of the average of such reported costs for all such designated hospitals statewide.

(iii) For inpatient services provided by specialty long term acute care hospitals and for inpatient services provided by cancer hospitals as so designated as of December thirty-first, two thousand eight, the operating cost component of such rates shall reflect the use of two thousand five operating costs for each respective category of facility as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes.

(iv) For facilities designated by the federal department of health and human services as exempt acute care children's hospitals as of December thirty-first, two thousand eight, for which a discrete institutional cost report was filed for the two thousand seven calendar year, and which has reported Medicaid discharges greater than fifty percent of total discharges in such cost report, shall be determined in accordance with the following:

(A) The operating cost component of such rates shall reflect the use of two thousand seven operating costs as reported by each facility to the department prior to July first, two thousand nine and as adjusted for the inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and as further adjusted as the commissioner deems appropriate, including transition adjustments. Such rates shall be determined on a per case basis or per diem basis, as set forth in regulations promulgated by the commissioner.

(B) The operating component of outpatient specialty rates of hospitals subject to this subparagraph shall reflect the use of two thousand seven operating costs as reported to the department prior to December first, two thousand eight, and shall include such adjustments as the commissioner deems appropriate.

(C) The base period reported operating costs used to establish inpatient and outpatient rates determined pursuant to this subparagraph shall be updated no less frequently than every two years and each such hospital shall submit such additional data as the commissioner may require to assist in the development of ambulatory patient groups (APGs) rates for such hospitals' outpatient specialty services.

(D) Notwithstanding any other provisions of law to the contrary and subject to the availability of federal financial participation, for all rate periods on and after April first, two thousand fourteen, the operating component of outpatient specialty rates of hospitals subject to this subparagraph shall be determined by the commissioner pursuant to regulations, including emergency regulations, and in consultation with such specialty outpatient facilities, provided however, that for the period beginning October first, two thousand thirteen through September thirtieth, two thousand fourteen, services provided to patients enrolled in medicaid managed care shall be paid by the medicaid managed care plans at no less than the otherwise applicable medicaid fee-for-service rates, as computed in accordance with clause (B) of this subparagraph for the period beginning October first, two thousand thirteen through March thirty-first, two thousand fourteen and as computed in accordance with this clause for the period beginning April first, two thousand fourteen through September thirtieth, two thousand fourteen.

(E) For facilities subject to the provisions of this subparagraph, the department shall examine the feasibility of reimbursing such facilities for services provided to children eligible for medical assistance on a non-fee-for-service basis. For purposes of this clause, "non-fee-for-service" shall be defined as an alternative payment method to bundle certain services rendered by such facility, including inpatient, outpatient, specialty outpatient and physician services, in amounts determined by the commissioner. The department shall examine:

(a) what services could be provided pursuant to the non-fee-for-service basis;

(b) how to ensure, for children enrolled in Medicaid managed care, that their health plans can continue to assist in the coordination of their care, particularly upon discharge from inpatient, outpatient or specialty outpatient services; and

(c) whether incentives should be incorporated for meeting quality

benchmarks or achieving efficiencies in the delivery and coordination of care or whether other means should be considered to achieve these objectives.

The department shall provide a report of its findings and recommendations to the governor and legislature no later than March first, two thousand fifteen.

(v) Rates established pursuant to this paragraph shall be deemed as excluding reimbursement for physician services for inpatient services and claims for Medicaid fee payments for such physician services for such inpatient care may be submitted separately from the rate in accordance with otherwise applicable law.

(vi) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

(vii) The commissioner may promulgate regulations, including emergency regulations, implementing the provisions of this paragraph, and, further, such regulations may provide for an update of the base year costs and statistics used to compute such rates, provided, however, that such base year update shall take effect no earlier than April first, two thousand fifteen, and provided further, however, that the commissioner may make such adjustments to such utilization and to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

(viii) The operating cost component of rates of payment pursuant to this paragraph for a general hospital or distinct unit of a general hospital without adequate cost experience shall be based on the lower of the facility's or unit's inpatient budgeted operating costs per day, adjusted to actual, or the applicable regional ceiling, if any.

(ix) The operating cost component of inpatient medicaid rates subject to subparagraphs (i), (ii) and (iii) of this paragraph shall, with regard to alternative level of care (ALC) days of care be subject to

computation pursuant to paragraph (h) of this subdivision.

* (f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section; provided however, commencing April first, nineteen hundred ninety-six the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group for patients eligible for payments made by state governmental agencies shall be reduced by five percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

* NB There are 2 par. (f)'s

* (f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section; provided however,

(i) commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods commencing April first, two thousand five through March thirty-first, two thousand six and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods commencing on and after April first, two thousand nine through March thirty-first, two thousand eleven, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

* NB Effective until December 31, 2029

* (f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating

certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section; provided however,

(i) commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

* NB Effective and expires December 31, 2029

* (f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

* NB Effective December 31, 2029

* NB There are 2 par (f)'s

(g) in cases where general hospitals or distinct units of general hospitals, other than those specified in paragraphs (e) and (f) of this subdivision, may be excluded from case based payments or receive an adjustment to case based payment rates. An exclusion or adjustment shall be provided only where the council, subject to the approval of the commissioner, determines that the case based rates of payment determined in accordance with this section would not reflect medically appropriate patterns of health resource use for such general hospital services efficiently and economically provided. If an exclusion is provided, then the reimbursement provisions contained in paragraph (e) of this subdivision shall apply. The commissioner shall provide to the council an analysis of the effect of case based payments on rural general hospitals and the council, subject to the above criteria and the approval of the commissioner, may exclude for any of the annual rate periods beginning on or after January first, nineteen hundred eighty-eight any of these general hospitals from case based payments or provide an adjustment to the case based payments in addition to that authorized in accordance with paragraph (f) of this subdivision;

(h) where alternate level of care (ALC) days are provided, a factor as determined in subparagraph (i) of this paragraph for the costs of these patients in a general hospital shall not be included in computations relating to the determination of general hospital case based rates of payment pursuant to this section. Alternate level of care days shall be days of care provided by a general hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary and are being provided by the general hospital. Separate rates of payment shall be established for such patients based on the level of care required and shall reflect: (i) operating costs based on the nineteen hundred eighty-seven regional average operating cost component of rates of payment for hospital based residential health care facilities determined in accordance with section twenty-eight hundred eight of this article and trended to the rate period, and (ii) additions contained in subparagraph (iii) of paragraph (a) of subdivision one of this section. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the rates calculated in accordance with this paragraph is not approved by the federal government, the council subject to the approval of the commissioner shall adopt regulations for such payments;

(i) if diagnosis-related groups are not adjusted or established in accordance with paragraph (a) of subdivision three of this section for services to acquired immune deficiency syndrome (AIDS) patients, then general hospitals shall receive separate payments for these patients based on regulations adopted by the council and approved by the commissioner;

(j) where general hospitals or distinct units of general hospitals are excluded from or receive an adjustment to case based payments per diagnosis-related group in accordance with paragraph (e), (f) or (g) of this subdivision, reimbursement shall continue to be calculated in accordance with such paragraph until the beginning of the rate period immediately following the date when the general hospital or the distinct unit of the general hospital is no longer excluded from or no longer receives an adjustment to case based payments per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of

the federal social security act (medicare), or until appropriate diagnosis-related groups have been developed for the specialized service provided by the general hospital or distinct unit of the general hospital, pursuant to paragraph (a) of subdivision three of this section; and

* (k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four. Commencing April first, nineteen hundred ninety-six, the operating cost component of rates of payment for patients eligible for payments made by a state governmental agency shall be reduced by five percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

* NB There are 2 par (k)'s

* (k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four.

(i) Commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and commencing April first, two thousand five through March thirty-first, two thousand six, and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods commencing on and after April first, two thousand nine through March thirty-first, two thousand eleven, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

* NB Effective until December 31, 2029

* (k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four.

(i) Commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the operating cost component

of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education for patients eligible for payments made by a state governmental agency shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

* NB Effective and expires December 31, 2029

* (k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

* NB Effective December 31, 2029

* NB There are 2 par (k)'s

(l) Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospitals which are certified by the office of alcoholism and substance abuse services to provide inpatient detoxification and withdrawal services and, with regard to inpatient services provided to patients discharged on and after December first, two thousand eight and who are determined to be in diagnosis-related groups as defined by the commissioner and published on the New York state department of health website, shall be made on a per diem basis in accordance with the following:

(i) for the period December first, two thousand eight through March thirty-first, two thousand nine, seventy-five percent of the operating cost component of such rates of payments shall reflect the operating cost component of rates of payment effective for December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and twenty-five percent of such rates shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph;

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, thirty-seven and five tenths percent of the operating cost component of such rates of payment shall reflect the operating cost component of rates of payment effective December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and sixty-two and five tenths percent of such rates of payment shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph;

(iii) for periods on and after April first, two thousand ten, one hundred percent of the operating cost component of such rates of payment shall reflect the use of two thousand six operating costs as reported to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph.

(iv) rates of payment computed in accordance with this paragraph and

reflecting the use of two thousand six base year operating costs shall be in accord with the following, provided, however that the commissioner may establish criteria under which reimbursement may be provided at higher percentages and for longer periods.

(A) For each of the regions within the state as described in clause (E) of this subparagraph the commissioner shall determine the average per diem cost incurred by general hospitals in that region subject to the provisions of this paragraph with regard to inpatients requiring medically managed detoxification services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services. In determining such costs the commissioner shall utilize two thousand six costs and statistics as reported by such hospitals to the department prior to two thousand eight.

(B) Per diem payments for inpatients requiring medically managed inpatient detoxification services shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located and as trended forward to adjust for inflation, provided however, that such payments shall be reduced by fifty percent for any such services provided on or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on or after the eleventh day.

(C) Per diem payments for inpatients requiring medically supervised withdrawal services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located for the period January first, two thousand nine through December thirty-first, two thousand nine, and as trended forward to adjust for inflation, and shall reflect seventy-five percent of such per diem amounts for periods on and after January first, two thousand ten, as trended forward to adjust for inflation, provided, however, that such payments shall be reduced by fifty percent for any services provided on or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on and after the eleventh day.

(D) Per diem payments for inpatients placed in observation beds, as

defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall be at the same level as would be paid pursuant to clause (A) of this paragraph, provided, however, that such payments shall not apply for more than two days of care, after which payments for such inpatients shall reflect their designation as requiring either medically managed detoxification services or medically supervised withdrawal services, and further provided that days of care provided in such observation beds shall, for reimbursement purposes, be fully reflected in the computation of the initial five days of care as set forth in clauses (A) and (B) of this subparagraph.

(E) For the purposes of this paragraph, the regions of the state shall be as follows:

(I) New York city, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;

(II) Long Island, consisting of the counties of Nassau and Suffolk;

(III) Northern metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;

(IV) Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;

(V) Utica/Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;

(VI) Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;

(VII) Rochester, consisting of Monroe, Ontario, Livingston, Wayne and Yates;

(VIII) Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

(F) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

(v) the commissioner may promulgate regulations, including emergency regulations, providing for an update of the base year costs and statistics used to compute rates of payment pursuant to this paragraph,

provided, however, that such base year update shall take effect no earlier than April first, two thousand fifteen, and provided further, however, that the commissioner may make such adjustments to such utilization and to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

5. Reimbursable inpatient operating cost component. (a) The reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group for general hospital inpatient hospital services shall be the product of the average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (b) of this subdivision, adjusted by a third-party payor of hospital services for uncovered services by such payor, and the weighting factors determined in accordance with paragraph (c) of subdivision three of this section.

(b) (i) For the rate year January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than ninety percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed ten percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section such that the composite sum equals one hundred percent.

(ii) For the rate year commencing January first, nineteen hundred eighty-nine, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than seventy-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed

twenty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

(iii) Except as provided in clause (C) of this subparagraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

** (A) Except as provided in clause (B) of this subparagraph and subparagraph (iv) of this paragraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

** NB There are 2 clause (A)'s

** (A) Except as provided in clauses (B) and (C) of this subparagraph and subparagraphs (iv), (v) and (vi) of this paragraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average

inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

** NB Effective until December 31, 2029

** (A) Except as provided in clause (B) of this subparagraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

** NB Effective December 31, 2029

** NB There are 2 clause (A)'s

* (B) For discharges on or after April first, nineteen hundred ninety-five for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies assigned to one of the twenty most common diagnosis-related groups for all general hospitals, the average reimbursable inpatient operating cost per discharge of a general hospital shall be the lower of (I) the amount determined in accordance with clause (A) of this subparagraph or (II) the average amount determined in accordance with clause (A) of this subparagraph for all general hospitals in the group category to which the hospital is assigned. The twenty most common diagnosis-related groups shall be determined using discharge data for the year two years prior to the rate year for all general hospitals, excluding beneficiaries of title XVIII of the federal social security act (medicare) and patients assigned to diagnosis related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit or exempt hospital patients.

* NB Expired March 31, 2011

* (C) (I) For discharges on or after July first, two thousand six through December thirty-first, two thousand six, and subject to the

availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

(II) For discharges on or after January first, two thousand seven through December thirty-first, two thousand seven, and subject to the availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

(III) For discharges on or after January first, two thousand eight through December thirty-first, two thousand eight, and subject to the availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

* NB Expired March 31, 2011

* (iv) for discharges on or after April first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses

reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB There are 3 subpar (iv)'s

* (iv) for discharges on or after April first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall to encourage improved productivity and efficiency be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in

subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB There are 3 subpar (iv)'s

* (iv) for discharges on or after April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph

(c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB Expires December 31, 2029

* NB There are 3 subpar (iv)'s

* (v) for discharges on or after August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average

reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus two and five-tenths percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus two and five-tenths percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB Expires December 31, 2029

* (vi) for discharges on or after April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and for discharges on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and for discharges on or after April first, two thousand through March thirty-first, two thousand five and for discharges on or after April first, two thousand five through March thirty-first, two thousand six, and for discharges on or after April first, two thousand six through March thirty-first, two thousand seven, and for discharges on or after April first, two thousand seven through March thirty-first, two thousand nine, and for discharges on or after April first, two thousand nine through March thirty-first, two thousand eleven, for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus three and thirty-three hundredths percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average

reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB Effective until December 31, 2029

* (vi) for discharges on or after April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and for discharges on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision

twenty-five of this section as amended;

(B) minus three and thirty-three hundredths percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

* NB Effective and expires December 31, 2029

* (c) Notwithstanding any inconsistent provision of this section, commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods on and after April first, two thousand nine through March thirty-first, two thousand eleven, rates of payment for a general hospital for patients eligible for payments made by state governmental agencies shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each general

hospital commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods on and after April first, two thousand nine through March thirty-first, two thousand eleven, as the result of (A) eighty-nine million dollars on an annualized basis for each year, multiplied by (B) the ratio of patient days for patients eligible for payments made by state governmental agencies provided in a base year two years prior to the rate year by a general hospital, divided by the total of such patient days summed for all general hospitals; and

(ii) (A) the result for each general hospital shall be allocated to units within such hospital exempt from case based rates of payment based on the ratio of such patient days provided in the exempt unit to the total of such patient days provided by the general hospital, and (B) the result divided by such patient days provided in the exempt unit, for a per diem unit of service reduction in rates of payment for such exempt unit for patients eligible for payments made by state governmental agencies for such general hospital; and

(iii) any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year for patients eligible for payments made by state governmental agencies, for a per case (or for exempt hospitals a per diem) unit of service reduction in rates of payment for patients eligible for payments made by state governmental agencies for such general hospital.

* NB Effective until December 31, 2029

* (c) Notwithstanding any inconsistent provision of this section, commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand rates of payment for a general hospital for patients eligible for payments made

by state governmental agencies shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each general hospital commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand as the result of (A) eighty-nine million dollars on an annualized basis for each year, multiplied by (B) the ratio of patient days for patients eligible for payments made by state governmental agencies provided in a base year two years prior to the rate year by a general hospital, divided by the total of such patient days summed for all general hospitals; and

(ii) (A) the result for each general hospital shall be allocated to units within such hospital exempt from case based rates of payment based on the ratio of such patient days provided in the exempt unit to the total of such patient days provided by the general hospital, and (B) the result divided by such patient days provided in the exempt unit, for a per diem unit of service reduction in rates of payment for such exempt unit for patients eligible for payments made by state governmental agencies for such general hospital; and

(iii) any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year for patients eligible for payments made by state governmental agencies, for a per case (or for exempt hospitals a per diem) unit of service reduction in rates of payment for patients eligible for payments made by state governmental agencies for such general hospital.

* NB Effective and expires December 31, 2029

6. Operating costs. (a) A general hospital's hospital-specific average reimbursable inpatient operating cost per discharge shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner based on the hospital's reimbursable inpatient operating cost base determined in accordance with paragraph (d) of subdivision one of this section; adjusted in accordance with paragraph (b) of this subdivision to reflect exceptions to case

payments; and projected to the applicable rate period by a trend factor determined in accordance with subdivision ten of this section; and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs; and adjusted in accordance with subparagraphs (i), (ii) and (iv) of paragraph (c) of this subdivision to reflect modifications to case payments; and standardized to reflect nineteen hundred eighty-seven hospital case mix. A general hospital's hospital-specific average reimbursable inpatient operating cost per discharge shall be adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section.

(b) In accordance with rules and regulations adopted by the council and approved by the commissioner, the commissioner shall adjust reimbursable inpatient operating costs and discharges to exclude operating costs and statistics related to specialized hospital services for which an alternative reimbursement methodology is adopted pursuant to paragraph (e) or (g) of subdivision four of this section, a factor for operating costs of patients who required an alternate level of care in accordance with paragraph (h) of subdivision four of this section and the operating costs and statistics of AIDS patients pursuant to paragraph (i) of subdivision four of this section if effective.

(c) In accordance with rules and regulations adopted by the council and approved by the commissioner, the commissioner shall adjust weighting factors developed pursuant to paragraph (c) of subdivision three of this section and reimbursable inpatient operating costs and statistics on which case payment rates are based to take into account the provisions for additional payments in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section. The rules and regulations are to be designed to identify an estimate of costs and statistics as if the payment methodology effective for the applicable rate period including payment based on the higher of high-cost outliers or long-stay outliers was in effect during the period used to establish such costs and statistics to accomplish the following:

(i) an estimate of costs for inpatient services to patients transferred to another general hospital receiving case payment rates

pursuant to paragraph (a) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs considering a transfer patient cost conversion factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; transfer patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such transfer patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the transfer patients are identified. Such costs shall be eliminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to adequately identify the costs related to transfer cases. Transfer cases shall be eliminated in computing discharges of the transferring hospital. The costs and discharges for transfer cases for each general hospital participating in the determination of the weighting factors shall be removed before calculating the weighting factors;

(ii) an estimate of costs for the outlier portion of inpatient services which would qualify for additional payments as cost outliers in accordance with paragraph (b) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs based on a general hospital's high cost percentage outlier factor, applied to an acute care cost component of such general hospital's reimbursable inpatient operating cost base after application of the trend factor and the addition of special additional inpatient operating costs. The high cost percentage outlier factor shall be calculated based on a determination of the percentage of nineteen hundred eighty-seven discharges of patients other than beneficiaries of title XVIII of the federal social security act (medicare) for which the commissioner has complete hospital bill submissions or such discharges during a recent twelve month period prior thereto established by regulation for which hospital bills are available, as follows, (a) for general hospitals that have complete hospital bill submissions for at least ninety percent of

their discharges, a high cost percentage outlier factor based on such data, and (b) for general hospitals that have complete hospital bill submissions for at least eighty percent but less than ninety percent of their discharges, a high cost percentage outlier factor based on such data plus an additional one-quarter of one percent, and (c) for general hospitals that have complete bill submissions for less than eighty percent of their discharges, a high cost percentage outlier factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals plus an additional one-quarter of one percent. The calculation of the high cost percentage outlier factor shall be subsequently reconciled by an adjustment to reflect the percentage of such complete hospital bill submissions for such nineteen hundred eighty-seven discharges as submitted to the commissioner prior to August first, nineteen hundred eighty-eight.

The minimum percentage threshold applicable pursuant to clause (a) of the first paragraph of this subparagraph may be increased to "at least ninety-five percent" and the percentage ceiling applicable pursuant to clause (b) of the first paragraph of this subparagraph increased to "less than ninety-five percent" pursuant to rules and regulations adopted by the council and approved by the commissioner based upon a study and a report by the commissioner of a sample of incomplete discharge records which showed that there was a significant difference in the value of high cost outlier cases potentially reflected in incomplete records from the value of high cost outlier cases reflected in records for which the commissioner has complete hospital bill submissions.

The maximum amount to be eliminated on a statewide basis shall be three percent of the total of nineteen hundred eighty-eight acute care cost components of general hospital reimbursable inpatient operating costs reimbursed on the case payment system. In the event that the total amount as calculated exceeds three percent, the calculated amount will be reduced to three percent by the application of a percentage computed by dividing expected outlier costs based on the three percent by actual outlier costs, which shall also be the percentage of outlier costs to be reimbursed in the payment year. The costs for the outlier portion of

cost outliers for general hospitals participating in the determination of the weighting factors shall be removed from each diagnosis-related group before determining the weighting factors;

* (iii) an estimate of inpatient costs which are related to a hospital stay in excess of the long stay threshold for long stay patients as defined in paragraph (c) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs in determining group category average inpatient reimbursable operating costs considering a long stay patient cost conversion factor, which shall be established at sixty percent provided, however, such long stay patient cost conversion factor may be revised for an annual rate period or periods beginning on or after January first, nineteen hundred eighty-nine in accordance with rules and regulations adopted by the council and approved by the commissioner; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; long stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such long stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the long stay patients are identified. The long stay outlier thresholds shall be determined by adding a sufficient number of standard deviations to the mean length of stay for each diagnosis-related group such that it is estimated for rates of payment during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety based upon nineteen hundred eighty-five data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three based upon nineteen hundred eighty-nine data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand based upon nineteen hundred ninety-two data from a representative sample of general hospitals that the costs associated

with the portion of hospital stays in excess of the long stay outlier thresholds do not exceed three percent of the total of the acute care cost components of reimbursable inpatient operating costs related to the determination of case based rates of payment. The costs associated with the outlier portion of long stay outliers for each general hospital participating in the determination of the weighting factors shall be removed from each diagnosis-related group before calculating the weighting factors;

* NB Effective until December 31, 2029

* (iii) an estimate of inpatient costs which are related to a hospital stay in excess of the long stay threshold for long stay patients as defined in paragraph (c) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs in determining group category average inpatient reimbursable operating costs considering a long stay patient cost conversion factor, which shall be established at sixty percent provided, however, such long stay patient cost conversion factor may be revised for an annual rate period or periods beginning on or after January first, nineteen hundred eighty-nine in accordance with rules and regulations adopted by the council and approved by the commissioner; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; long stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such long stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the long stay patients are identified. The long stay outlier thresholds shall be determined by adding a sufficient number of standard deviations to the mean length of stay for each diagnosis-related group such that it is estimated for rates of payment during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety based upon nineteen hundred eighty-five data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three based upon

nineteen hundred eighty-nine data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-nine based upon nineteen hundred ninety-two data from a representative sample of general hospitals that the costs associated with the portion of hospital stays in excess of the long stay outlier thresholds do not exceed three percent of the total of the acute care cost components of reimbursable inpatient operating costs related to the determination of case based rates of payment. The costs associated with the outlier portion of long stay outliers for each general hospital participating in the determination of the weighting factors shall be removed from each diagnosis-related group before calculating the weighting factors;

* NB Effective and expires December 31, 2029

* (iii) an estimate of inpatient costs which are related to a hospital stay in excess of the long stay threshold for long stay patients as defined in paragraph (c) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs in determining group category average inpatient reimbursable operating costs considering a long stay patient cost conversion factor, which shall be established at sixty percent provided, however, such long stay patient cost conversion factor may be revised for an annual rate period or periods beginning on or after January first, nineteen hundred eighty-nine in accordance with rules and regulations adopted by the council and approved by the commissioner; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; long stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such long stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the long stay patients are identified. The long stay outlier thresholds shall be determined by adding a sufficient number of standard deviations to the mean length of stay for each diagnosis-related group such that it is estimated for rates of payment during the period January

first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety based upon nineteen hundred eighty-five data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three based upon nineteen hundred eighty-nine data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six based upon nineteen hundred ninety-two data from a representative sample of general hospitals that the costs associated with the portion of hospital stays in excess of the long stay outlier thresholds do not exceed three percent of the total of the acute care cost components of reimbursable inpatient operating costs related to the determination of case based rates of payment. The costs associated with the outlier portion of long stay outliers for each general hospital participating in the determination of the weighting factors shall be removed from each diagnosis-related group before calculating the weighting factors;

* NB Effective December 31, 2029

(iv) an estimate of inpatient costs which are related to short stay patients as defined in paragraph (d) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs considering a short stay patient cost conversion factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; short stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such short stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the short stay patients are identified. Such costs shall be eliminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to adequately identify the costs related to short stay

patients. Short stay cases shall be eliminated in computing discharges of a general hospital. The costs and discharges for short stay cases for each general hospital participating in the determination of the weighting factors shall be removed before calculating the weighting factors.

7. Operating cost group component. (a) A general hospital's group category average inpatient reimbursable operating cost per discharge (price) shall be a composite factor determined in accordance with rules and regulations adopted by the council and approved by the commissioner based on a group price component determined in accordance with subparagraph (i) of this paragraph, a hospital-specific price component determined in accordance with subparagraph (ii) of this paragraph, and an adjustment in accordance with subparagraph (iii) of this paragraph.

(i) The group price component shall be based on the costs and statistics of general hospitals in the group category established pursuant to paragraph (b) of this subdivision to which the hospital is assigned by the commissioner to compute a group based average inpatient reimbursable operating cost per discharge for the group category. General hospital costs and statistics shall be determined consistent with the methodology to determine hospital-specific average reimbursable inpatient operating cost per discharge pursuant to subdivision six of this section; adjusted to reflect additional cost increases in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section; and adjusted to exclude the components of hospital-specific inpatient reimbursable operating costs related to education, physician, ambulance services and organ acquisition costs determined in accordance with paragraph (c) of this subdivision and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section associated with cost increases in such costs; and adjusted to exclude the components of special additional inpatient operating costs determined and allocated in accordance with clauses (B), (D), (H), and (I) of subparagraph (iii) and clauses (A), (E) and (F) of subparagraph (iv) of paragraph (e) of subdivision one of this section; and adjusted to reflect additional modifications to case payments in

accordance with subparagraph (iii) of paragraph (c) of subdivision six of this section. The group based average inpatient reimbursable operating costs computed for a general hospital shall be adjusted to reflect the hospital-specific indirect medical education costs percentage of such hospital determined in accordance with subparagraph (ii) of paragraph (c) of this subdivision.

Hospital costs shall be standardized for comparison purposes considering differences in wage and wage-related costs levels and such other economic factors, such as a power equalization factor, as may be determined in accordance with rules and regulations adopted by the council and approved by the commissioner.

(ii) A hospital-specific price component shall be determined for each general hospital based on such hospital's hospital-specific education, physician, ambulance services and organ acquisition costs determined in accordance with subparagraphs (i), (iii) and (iv) of paragraph (c) of this subdivision and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section associated with cost increases in such costs, and special additional inpatient operating costs determined and allocated in accordance with clauses (B), (D), (H) and (I) of subparagraph (iii) and clauses (A), (E) and (F) of subparagraph (iv) of paragraph (e) of subdivision one of this section, as excluded pursuant to subparagraph (i) of this paragraph, per discharge, standardized to reflect nineteen hundred eighty-seven hospital case mix.

(iii) A general hospital's group category average inpatient reimbursable operating cost per discharge shall be adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section.

(b) General hospital group categories shall be established in accordance with rules and regulations adopted by the council and approved by the commissioner for purposes of computing group category average inpatient reimbursable operating cost per discharge considering, but not limited to, factors such as hospital size, hospital medical education activity, teaching status and geographic divisions of the

state.

(c) Education, physician, ambulance services and organ acquisition costs shall include:

(i) direct medical education expenses, defined as the reimbursable costs of residents, fellows, and supervising physicians, combined with the costs of hospital based physicians;

(ii) indirect medical education expenses, defined as an estimate of the costs, other than direct costs, of educational activities in teaching hospitals attributable to factors including but not limited to increased overhead, more severely ill patients and the tendency of residents to provide more tests than experienced licensed physicians. For the rate period beginning January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred eighty-eight, an estimate of indirect medical education costs shall be determined in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs for reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period. The council may adopt rules and regulations, subject to the approval of the commissioner, to revise the methodology for the determination of an estimate of indirect medical education costs to reflect revisions to the methodology applicable for purposes of determining reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate period. For annual rate periods beginning on or after January first, nineteen hundred eighty-nine an estimate of indirect medical education costs shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner;

(iii) the reimbursable costs of schools of nursing, allied professional programs and ambulance services; and

(iv) the reimbursable costs of organ acquisition services not reimbursed pursuant to the methodology applicable for purposes of reimbursement pursuant to title XVIII of the federal social security act (medicare).

(d) The commissioner shall establish, in accordance with rules and regulations adopted by the council and approved by the commissioner, the

methodology to determine the hospital's group category average inpatient reimbursable operating cost per discharge (price) and the percentage amounts, pursuant to subparagraphs (i), (ii) and (iii) of paragraph (b) of subdivision five of this section, of the group category average inpatient reimbursable operating cost per discharge to be used to determine the inpatient reimbursable operating cost component of case based rates for annual rate periods beginning on or after January first, nineteen hundred eighty-eight.

8. Capital related inpatient expenses. (a) Capital related inpatient expenses including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on major movable equipment if requested by the hospital, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to such article and article twenty-eight of this chapter), shall be included in rates of payment determined pursuant to this section based on a budget for capital related inpatient expenses and subsequently reconciled to actual expenses and statistics through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital expenditure which requires or required approval pursuant to this article must have received such approval for any capital related expense generated by such capital expenditure to be included in rates of payment. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The submitted budget may include the capital related inpatient expenses for all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year or during the rate year provided all required approvals have been obtained.

The council shall adopt, with the approval of the commissioner,

regulations to:

- (i) identify by type the eligible capital related inpatient expenses;
- (ii) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;
- (iii) provide authorization to adjust inpatient rates by advancing payment of depreciation as needed, in instances of capital debt related financial distress of voluntary, non-profit general hospitals; and
- (iv) provide a methodology for the reimbursement treatment of sales.

(b) Capital related inpatient expenses shall be included in case based payments based on the hospital's average capital related inpatient expenses per discharge. Adjustments shall be made to capital related costs and statistics to reflect capital related inpatient expenses reimbursed on a per diem basis in accordance with paragraphs (a), (d), (e), (g) and (i) of subdivision four of this section.

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

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

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

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

(v) For rates effective on and after April first, two thousand twenty-six, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance with paragraph (a) of this subdivision, shall be reduced by ten percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision shall be reduced by ten percent relative to the rate in effect on such date. Such rate adjustments shall be subject to federal financial participation.

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

(vii) For any rate year, all reconciliation add-on amounts calculated for the period October first, two thousand twenty-four through March thirty-first, two thousand twenty-six shall be reduced by twenty percent, and all reconciliation recoupment amounts calculated for the

period October first, two thousand twenty-four through March thirty-first, two thousand twenty-six, shall increase by twenty percent. Such rate adjustments shall be subject to federal financial participation.

(viii) For any rate year, all reconciliation add-on amounts calculated on and after April first, two thousand twenty-six shall be reduced by ten percent, and all reconciliation recoupment amounts calculated on or after April first, two thousand twenty-six shall increase by ten percent. Such rate adjustments shall be subject to federal financial participation.

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

* (e) Notwithstanding any inconsistent provision of this subdivision, commencing April first, nineteen hundred ninety-five, when a factor for reconciliation of budgeted capital related inpatient expenses to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such capital related inpatient expenses component of rates of payment shall be reduced by the commissioner by the difference between the reconciled capital related inpatient expenses included in rates of payment determined in accordance with paragraphs (a), (b) and (c) of this subdivision for such prior year and capital related inpatient expenses for such prior year calculated based on the hospital's average capital related inpatient expenses computed on a per diem basis.

* NB Effective through March 31, 2029

* (f) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five for purposes of determining the capital related inpatient expenses component of rates of

payment for patients eligible for payments made by state governmental agencies for a rate year, the submitted budget for capital related inpatient expenses of a general hospital applicable to the rate year shall be decreased by the commissioner to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses.

* NB Effective through March 31, 2029

* (g) Notwithstanding any inconsistent provision of this article, commencing April first, nineteen hundred ninety-five for rates of payment for patients eligible for payments made by state governmental agencies, the capital related inpatient expenses component determined in accordance with paragraph (a) of this subdivision and the capital cost per visit components determined in accordance with subparagraphs (i) and (ii) of paragraph (g) of subdivision two of section twenty-eight hundred seven of this article shall be adjusted by the commissioner to exclude such expenses related to:

- (i) forty-four percent of the costs of major movable equipment; and
- (ii) staff housing.

* NB Effective through March 31, 2029

9. Adjustments. For annual rate periods beginning on or after January first, nineteen hundred eighty-eight:

(a) The commissioner shall on his own initiative, or on the basis of a request from a general hospital, adjust an established rate to reflect:

(i) the reduction of costs related to the elimination of a general hospital inpatient service in instances where the costs of such service were included in the rate established; and

(ii) the correction of errors or omissions of data or in computation.

(b) General hospitals may request and the commissioner shall consider an adjustment to an established rate to reflect increased expenses in excess of costs reported by the general hospital in the nineteen hundred eighty-five cost report, after application of the trend factor, or reconsideration of disallowed expenses based on:

(i) justification of all or a portion of expenses not included in the rate resulting from the cost analysis process contained in subparagraph (i) of paragraph (a) of this subdivision;

(ii) additional operational expenses related to approved construction or service changes;

(iii) the addition of costs related to a state requirement for additional services to be provided or additional costs to be incurred in meeting state and federal requirements;

(iv) additional operational expenses to permit a more efficient and economical method of delivering a service;

(v) increased costs determined to be needed to recruit or maintain an appropriate level of personnel providing professional services to patients; and

(vi) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established rate related to subparagraph (vi) of paragraph (b) of this subdivision, the commissioner shall consider:

(i) the fiscal capability of the general hospital to finance such increases from its own resources;

(ii) the past history of the general hospital with respect to compensation increases and allowed compensation trend factors; and

(iii) the economy in the area in which the general hospital is located.

(d) General hospitals may request and the commissioner shall consider a change in assignment among the group categories established pursuant to paragraph (b) of subdivision seven of this section to which the hospital is assigned for purposes of computing group category average reimbursable inpatient operating cost per discharge.

(e) (i) Volume adjustments which would result in revisions in case payment rates shall not be made to reflect increases or decreases in discharges for other than beneficiaries of title XVIII of the federal social security act (medicare) in rate years beginning on or after January first, nineteen hundred eighty-eight, except in those specific instances where a decrease in volume as measured by discharges, including discharges of patients for whom reimbursement is provided on a per diem basis in accordance with paragraph (a) of subdivision eleven of this section, is equal to or greater than one percent of discharges in nineteen hundred eighty-seven for those general hospitals having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services

provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, or equal to or greater than ten percent of discharges in nineteen hundred eighty-seven for all other general hospitals, and the failure to make such adjustment seriously impacts on the financial stability of a needed hospital, and except in those specific instances where an increase in volume as measured by discharges is equal to or greater than ten percent of discharges in nineteen hundred eighty-seven. Provided, however, that an adjustment for volume increases shall not apply to those general hospitals having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety. For general hospitals and distinct units of general hospitals not reimbursed on a case based payment per discharge basis, volume adjustments may be made during the above indicated rate years in accordance with regulations adopted by the council and approved by the commissioner.

(ii) The commissioner shall adjust the rates for those general hospitals and units of general hospitals excluded from case payment in accordance with paragraph (e) or (g) of subdivision four of this section for case mix changes for other than beneficiaries of title XVIII of the federal social security act (medicare).

(f) General hospitals that did not qualify for a volume adjustment for the nineteen hundred eighty-six and nineteen hundred eighty-seven rate periods for rates of payment determined in accordance with section twenty-eight hundred seven-a of this article may request and the commissioner shall consider an adjustment to an established case based rate of payment for nineteen hundred eighty-eight based on increases in

volume as measured by discharges, based on a comparison between nineteen hundred eighty-five and nineteen hundred eighty-seven discharges, excluding in such comparison discharges of patients who are beneficiaries of title XVIII of the federal social security act (medicare) and discharges related to transfer cases (transferring hospital) and short stay cases as defined in this section, provided such general hospital meets performance criteria established in accordance with rules and regulations adopted by the council and approved by the commissioner. Such criteria shall include but need not be limited to: maintenance of like patient occupancy rates for the rate periods nineteen hundred eighty-five, nineteen hundred eighty-six and nineteen hundred eighty-seven; a reduction in patient length of stay for other than beneficiaries of title XVIII of the federal social security act (medicare) based on a comparison with nineteen hundred eighty-five data; and an expanded use of ambulatory surgery by the general hospital based on a comparison with nineteen hundred eighty-five data. Such adjustment shall consider, but need not be limited to, the variable costs related to volume changes in accordance with rules and regulations adopted by the council and approved by the commissioner.

(g) All appeals shall be submitted to the commissioner, who may submit a copy of the appeal to interested parties for the purpose of providing an opportunity for comment within a specified time period.

(h) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the rate is effective provided that all information necessary to determine whether an adjustment is justified is submitted by the facility prior to May first of such year. In the event such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

* 10. Trend factors. (a) The commissioner, in accordance with the methodology developed for rate periods through March thirty-first, two thousand, for rates of payment for state governmental agencies and through December thirty-first, nineteen hundred ninety-six for rates of payment for all other payors pursuant to paragraph (b) of this subdivision, shall establish trend factors to project for the effects of

inflation. The factors shall be applied to the appropriate portion of reimbursable costs. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed for rate periods through March thirty-first, two thousand, for rates of payment for state governmental agencies and through December thirty-first, nineteen hundred ninety-six for rates of payment for all other payors by four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner. For nineteen hundred ninety-six, through March thirty-first, two thousand, the commissioner shall apply the nineteen hundred ninety-five trend factor methodology. The commissioner shall monitor the actual price movements of the external price indicators used in the methodology for one interim adjustment to the trend factors to reflect such price movements and one final adjustment to the trend factors to reflect such price movements. At the same time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factors.

(c) (1) For rate periods on and after April first, two thousand, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.

(2) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.

(3) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau

of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in subparagraph two of this paragraph and any difference will be included in the prospective trend factor for the current year.

(4) At the time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

* NB Effective until December 31, 2029

* 10. Trend factors. (a) The commissioner, in accordance with the methodology developed pursuant to paragraph (b) of this subdivision, shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner. On or about September first of each year, the consultants shall provide to the commissioner and the council a report in writing detailing the methodology to be used to determine the trend factors for the subsequent twelve month period commencing January first. The commissioner shall monitor the actual price movements during this twelve month period of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factor was established. At the same time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factors.

* NB Effective December 31, 2029

11. Special provisions. (a) Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, payment for inpatient hospital services provided on or after January first, nineteen hundred eighty-eight to a patient admitted to a general hospital prior to January first, nineteen hundred eighty-eight otherwise eligible for payment on a case based payment per discharge basis for a diagnosis-related group shall be at the rate of payment for such general hospital for such patient in effect for December thirty-first, nineteen hundred eighty-seven provided, however, that the operating cost components of such rates of payment for inpatient hospital services provided on or after January first, nineteen hundred eighty-eight shall be projected to the rate period by the trend factor determined in accordance with subdivision ten of this section and reconciled on a cumulative basis on or about March thirty-first, nineteen hundred eighty-eight and December thirty-first, nineteen hundred eighty-eight for payment of adjusted rates of payment based on such trend factor adjustment. The component of such rates of payment based on the allowances provided in accordance with paragraphs (e) and (f) of subdivision eight of section twenty-eight hundred seven-a of this article shall be returned to the applicable regional pool created in accordance with subdivision fifteen of such section and distributed in accordance with subdivision sixteen of such section based on needs for the financing of losses resulting from bad debts and the costs of charity care as determined for purposes of nineteen hundred eighty-seven distributions.

(b) The council shall adopt rules and regulations subject to the approval of the commissioner regarding payor payment responsibilities when a patient has coverage with more than one payor for general hospital inpatient services and during a hospital stay exhausts benefits available from the primary payor, or receives services not reimbursed by the primary payor, so that the hospital shall be reimbursed by a secondary payor for services not reimbursed by the primary payor that are included as a benefit of the secondary payor. A primary payor for purposes of this paragraph shall include benefits available pursuant to title XVIII of the federal social security act (medicare).

* (c)(i) Adjustments to rates made pursuant to this section for rate

periods commencing on or after January first, nineteen hundred ninety-seven may be made prospectively or retrospectively on the next following January or July unless otherwise specifically authorized.

(ii) The commissioner may further adjust rates retrospectively for payments by state governmental agencies upon a finding that the failure to do so seriously impacts on a general hospital's financial stability.

(iii) Regardless of whether rates are adjusted prospectively or retrospectively the authorized dollar value of the adjustment shall be the same, calculated by including the retroactive impact of such adjustment if such adjustment is made prospectively. A prospective adjustment to reflect the retroactive impact of an adjustment shall be included in the determination of rates of payment for a prospective rate period based on the methodology applied in accordance with this section for calculation of rates of payment for such prospective rate period. The allowance reflected in payments to a general hospital or a pool related to a prospective adjustment which reflects the retroactive impact of an adjustment shall be computed based on the allowance percentage in effect during the prospective period such adjustment is in effect. No recalculation of the basis for distribution of funds from bad debt and charity care regional pools determined in accordance with subdivision seventeen of this section shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment.

* NB Effective until December 31, 2029

* (c)(i) Adjustments to rates made pursuant to this section shall be made prospectively on the next following January or July unless otherwise specifically authorized provided, however, that adjustments to rates of payment to reflect nineteen hundred eighty-seven data and statistics may be made retrospectively and such retrospective adjustments shall, to the extent practicable, be cumulated for one comprehensive adjustment.

(ii) The commissioner may further adjust rates retrospectively upon a finding that the failure to do so seriously impacts on a general hospital's financial stability.

(iii) Regardless of whether rates are adjusted prospectively or retrospectively the authorized dollar value of the adjustment shall be the same, calculated by including the retroactive impact of such adjustment if such adjustment is made prospectively. A prospective

adjustment to reflect the retroactive impact of an adjustment shall be included in the determination of rates of payment for a prospective rate period based on the methodology applied in accordance with this section for calculation of rates of payment for such prospective rate period, provided, however, that no recalculation of bad debt and charity care allowance percentages determined in accordance with subdivision fourteen of this section shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment. The bad debt and charity care allowance of a general hospital related to a prospective adjustment which reflects the retroactive impact of an adjustment shall be computed based on the bad debt and charity care allowance percentage of such hospital in effect during the prospective period such adjustment is in effect. No recalculation of the basis for distribution of funds from bad debt and charity care regional pools determined in accordance with subdivision seventeen of this section shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment.

* NB Effective December 31, 2029

(d) Working capital. General hospitals may include as a financing or working capital charge an addition of two percent of any valid claim not paid within thirty days of submission or determination of payor liability, whichever is later, and one percent per month thereafter. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in an advance payment system. Any payor not participating in an advance payment system or offering admission billing shall allow interim billing for a patient whose stay exceeds thirty days.

(e) (i) Except for payments made pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law, a two percent discount from general hospital payments shall be available to all payors whose payments are calculated in accordance with paragraphs (b) and (c) of subdivision one of this section making payment in full to a general hospital for covered hospital services within ten calendar days of receipt from the hospital by the appropriate payor of a bill for such services.

(ii) A three percentage point reduction in the differential of five percent for general hospital payments shall be available to all payors

whose payments are calculated in accordance with paragraph (b) of subdivision one or paragraph (e) of subdivision four of this section which are making payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law when such payments are made in full to a general hospital for covered hospital services within ninety calendar days of receipt from the hospital by the appropriate payor of a bill for such services, and an additional two percentage point reduction shall be available for such payors if such payment is made within forty-five calendar days of receipt of such a bill.

(f) (i) * In order to allow for real increases in general hospital case mix while limiting the effect of potential case mix changes that are the result of changes in coding practices rather than real changes in case mix, the commissioner shall annually for rate periods through December thirty-first, nineteen hundred ninety-six, in accordance with rules and regulations adopted by the council and approved by the commissioner, adjust individual general hospitals' case payment rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase determined in accordance with this subparagraph. The commissioner further shall adjust individual general hospitals' case payment rates determined in accordance with this section for state governmental agencies for the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand and on and after April first, two thousand, in accordance with clause (G) of this subparagraph and to account for increases in statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups based on data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations, that exceed the allowable statewide increase determined in accordance with clause (B-1) of this subparagraph.

* NB Effective until December 31, 2029

* In order to allow for real increases in general hospital case mix

while limiting the effect of potential case mix changes that are the result of changes in coding practices rather than real changes in case mix, the commissioner shall annually for rate periods through December thirty-first, nineteen hundred ninety-six, in accordance with rules and regulations adopted by the council and approved by the commissioner, adjust individual general hospitals' case payment rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase determined in accordance with this subparagraph. The commissioner further shall adjust individual general hospitals' case payment rates determined in accordance with this section for state governmental agencies for the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand in accordance with clause (G) of this subparagraph and to account for increases in statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups based on data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations, that exceed the allowable statewide increase determined in accordance with clause (B-1) of this subparagraph.

* NB Effective and expires December 31, 2029

* In order to allow for real increases in general hospital case mix while limiting the effect of potential case mix changes that are the result of changes in coding practices rather than real changes in case mix, the commissioner shall annually, in accordance with rules and regulations adopted by the council and approved by the commissioner, adjust individual general hospitals' case payment rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase determined in accordance with this subparagraph.

* NB Effective December 31, 2029

(A) The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-three from the nineteen hundred eighty-seven statewide average case mix shall not exceed two percent in nineteen hundred eighty-eight compared to nineteen hundred eighty-seven, three percent in nineteen hundred eighty-nine compared to nineteen hundred eighty-seven, four percent in nineteen hundred ninety compared to nineteen hundred eighty-seven, five percent in nineteen hundred ninety-one compared to nineteen hundred eighty-seven, and, notwithstanding any inconsistent rule or regulation, for rates of payment for state governmental agencies six percent in nineteen hundred ninety-two compared to nineteen hundred eighty-seven and seven percent in nineteen hundred ninety-three compared to nineteen hundred eighty-seven, and for rates of payment for payors other than state governmental agencies six and seven-tenths percent in nineteen hundred ninety-two compared to nineteen hundred eighty-seven and seven percent in nineteen hundred ninety-three compared to nineteen hundred eighty-seven.

* (B) The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six from the nineteen hundred ninety-two statewide average case mix, plus adjustments, shall not exceed: for rates of payment for state governmental agencies two percent in the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-four, and, notwithstanding any inconsistent rule or regulation, six and two-tenths percent in the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, three percent in the period January first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-five, two percent in the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, and three percent in the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six; and for rates of payment for payors other than state governmental agencies two percent in nineteen hundred ninety-four, three percent in nineteen hundred ninety-five, and four

percent in the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six. Adjustments to the nineteen hundred ninety-two statewide average case mix shall mean an adjustment for any increase in nineteen hundred ninety-two statewide average case mix compared to nineteen hundred eighty-seven statewide average case mix in excess of six percent of nineteen hundred eighty-seven statewide average case mix and a further adjustment to reflect that measurement of case mix increase from the nineteen hundred ninety-two statewide average case mix rather than the nineteen hundred eighty-seven statewide average case mix reflects the increase in statewide average case mix from nineteen hundred eighty-seven to nineteen hundred ninety-two in order to maintain the effective maximum rate of allowable statewide average case mix increases at a percentage per year of the nineteen hundred eighty-seven statewide average case mix. Nineteen hundred ninety-two case mix shall be determined based on nineteen hundred ninety-two data received by the department by April thirtieth, nineteen hundred ninety-three.

* NB Effective until December 31, 2029

* (B) The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six from the nineteen hundred ninety-two statewide average case mix, plus adjustments, shall not exceed: for rates of payment for state governmental agencies two percent in the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-four, and, notwithstanding any inconsistent rule or regulation, six and two-tenths percent in the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, three percent in the period January first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-five, and two percent in the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, and three percent in the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six; and for rates of payment for payors other than state governmental agencies two percent in nineteen hundred ninety-four, three percent in nineteen hundred ninety-five, and four percent in the period January first, nineteen hundred ninety-six through June thirtieth,

nineteen hundred ninety-six. Adjustments to the nineteen hundred ninety-two statewide average case mix shall mean an adjustment for any increase in nineteen hundred ninety-two statewide average case mix compared to nineteen hundred eighty-seven statewide average case mix in excess of six percent of nineteen hundred eighty-seven statewide average case mix and a further adjustment to reflect that measurement of case mix increase from the nineteen hundred ninety-two statewide average case mix rather than the nineteen hundred eighty-seven statewide average case mix reflects the increase in statewide average case mix from nineteen hundred eighty-seven to nineteen hundred ninety-two in order to maintain the effective maximum rate of allowable statewide average case mix increases at a percentage per year of the nineteen hundred eighty-seven statewide average case mix. Nineteen hundred ninety-two case mix shall be determined based on nineteen hundred ninety-two data received by the department by April thirtieth, nineteen hundred ninety-three.

* NB Effective December 31, 2029

(B-1) The increase in the statewide average case mix in the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand six and on and after April first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, from the statewide average case mix for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six shall not exceed one percent for nineteen hundred ninety-seven, two percent for nineteen hundred ninety-eight, three percent for the period January first, nineteen hundred ninety-nine through September thirtieth, nineteen hundred ninety-nine, four percent for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and four percent for two thousand plus an additional one percent per year thereafter, based on comparison of data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations.

(C) Rate year case mix shall be determined based on rate year data

received by the department by April thirtieth next following the end of the rate year. Case mix may be determined based on general hospital data received or amended after such due dates provided, however, that a general hospital that does not submit the appropriate data in a timely manner shall be subject to the provisions of section twelve-d of this chapter.

* (D) If in any rate period on an annualized basis the cumulative case mix increase exceeds the allowable statewide increase, rates of payment to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase.

Notwithstanding any inconsistent provision of this paragraph, rate adjustments for purposes of this paragraph shall be made on a six month rate period basis for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four. The retroactive impact of adjustments to rates of payment for payors other than state governmental agencies based on the amendments to this paragraph effective July first, nineteen hundred ninety-four shall be reflected in a prospective adjustment to rates of payment for such payors for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four.

* NB Effective until December 31, 2029

* (D) If in any rate year the cumulative case mix increase exceeds the allowable statewide increase, rates of payment to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase. Notwithstanding any inconsistent provision of this paragraph, rate adjustments for purposes of this paragraph shall be made on a six month rate period basis for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four. The retroactive impact of adjustments to rates of payment for payors other than state governmental agencies based on the amendments to this paragraph effective July first,

nineteen hundred ninety-four shall be reflected in a prospective adjustment to rates of payment for such payors for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four.

* NB Effective December 31, 2029

(E) Such methodology shall take into account past trends of individual general hospitals' case mix changes, and, within the aggregate allowable statewide increase in case mix, permit general hospitals to appeal to the commissioner their proposed allocation of a reduction in rates of payment related to increases in statewide average case mix based on such factors as changes in hospital service delivery and referral patterns.

(F) Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization shall not be subject to this limitation.

* (G) Adjustments determined in accordance with clause (B) of this subparagraph for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six on a final basis, and in accordance with subparagraph (ii) of this paragraph on an interim basis, shall be applied to rates of payment for state governmental agencies during the period January first, nineteen hundred ninety-seven through March thirty-first, two thousand and periods on and after April first, two thousand.

* NB Expires December 31, 2029

* (G) Adjustments determined in accordance with clause (B) of this subparagraph for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six on a final basis, and in accordance with subparagraph (ii) of this paragraph on an interim basis, shall be applied to rates of payment for state governmental agencies during the period January first, nineteen hundred ninety-seven through March thirty-first, two thousand.

* NB Effective and repealed December 31, 2029

* (ii) (A) The commissioner shall, in accordance with rules and regulations adopted by the council and approved by the commissioner, for purposes of payments on an interim basis periodically compute an adjustment to individual general hospitals' case payment rates for prior periods for the payor categories specified in paragraphs (a) and (b) of subdivision one of this section to account for increases in the

statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase. The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-three from the nineteen hundred eighty-seven statewide average case mix and in a rate year during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six from the adjusted nineteen hundred ninety-two statewide average case mix shall not exceed the allowable statewide increase as determined in accordance with subparagraph (i) of this paragraph. Adjustments may be made on a quarterly basis consistent with this annual limitation. If in any quarter of the rate year the cumulative case mix increase for the rate year exceeds the allowable statewide increase, payment rates to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals provided, however, that any funds to be recovered from hospitals based on such adjustments for prior periods shall be recovered by prospective adjustment of rates of payment in accordance with paragraph (c) of this subdivision, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase, taking into consideration the effect of any adjustment applicable in the rate period made in accordance with subparagraph (iii) of this paragraph. Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization shall not be subject to this limitation, pursuant to rules and regulations adopted by the council and approved by the commissioner.

(B) The commissioner further shall for purposes of payments on an interim basis periodically compute an adjustment to individual general hospitals' case payment rates for prior periods for payments made by state governmental agencies to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for patients that are eligible for medical

assistance pursuant to title eleven of article five of the social services law eligible for payments made by state governmental agencies or by health maintenance organizations, that exceed the allowable statewide increase as determined in accordance with clause (B-1) of subparagraph (i) of this paragraph.

* NB Effective until December 31, 2029

* (ii) The commissioner shall, in accordance with rules and regulations adopted by the council and approved by the commissioner, for purposes of payments on an interim basis periodically compute an adjustment to individual general hospitals' case payment rates for prior periods for the payor categories specified in paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase. The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-three from the nineteen hundred eighty-seven statewide average case mix and in a rate year during the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six from the adjusted nineteen hundred ninety-two statewide average case mix shall not exceed the allowable statewide increase as determined in accordance with subparagraph (i) of this paragraph. Adjustments may be made on a quarterly basis consistent with this annual limitation. If in any quarter of the rate year the cumulative case mix increase for the rate year exceeds the allowable statewide increase, payment rates to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals provided, however, that any funds to be recovered from hospitals based on such adjustments for prior periods shall be recovered by prospective adjustment of rates of payment in accordance with paragraph (c) of this subdivision, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase, taking into consideration the effect of any adjustment

applicable in the rate period made in accordance with subparagraph (iii) of this paragraph. Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization shall not be subject to this limitation, pursuant to rules and regulations adopted by the council and approved by the commissioner.

* NB Effective December 31, 2029

(iii) The commissioner shall, in accordance with rules and regulations adopted by the council and approved by the commissioner, periodically prospectively adjust for purposes of payments on an interim basis individual general hospitals' case payment rates for the payor categories specified in paragraphs (a) and (b) of subdivision one of this section to account for increases in statewide average assignment to diagnosis-related groups which exceed the allowable statewide increase as determined in accordance with subparagraph (ii) of this paragraph.

(iv) Rates of payment of a general hospital shall be adjusted in accordance with paragraph (c) of this subdivision to reflect the difference between an individual general hospital's case payment rates adjusted in accordance with subparagraph (i) of this paragraph for a rate period and such rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section, taking into consideration any adjustment to case payment rates applicable for such rate period made in accordance with subparagraphs (ii) and (iii) and for the periods beginning on or after July first, nineteen hundred ninety, subparagraph (v) of this paragraph.

(v) Notwithstanding any inconsistent provision of law, for the periods beginning on or after July first, nineteen hundred ninety and subsequent annual rate periods beginning January first the commissioner shall reduce, in accordance with the methodology adopted for purposes of adjustments pursuant to subparagraph (ii) of this paragraph, for purposes of payments on an interim basis individual general hospitals' case payment rates applicable to state governmental agencies for a prospective period to reflect an estimate of the cumulative increase in statewide average assignment to diagnosis-related groups for prior periods including prior quarters of the rate period which exceeds the allowable statewide increase specified in subparagraph (i) of this paragraph for the prospective period. Such adjustment if effected for

less than an annual prospective rate period shall reflect an annualized adjustment.

(vi) Notwithstanding any inconsistent provision of law, adjustments to rates of payment pursuant to this paragraph based on nineteen hundred ninety-three data that reflects an increase in statewide average case mix compared to nineteen hundred eighty-seven that exceeds the increase based on nineteen hundred ninety-two data in statewide average case mix compared to nineteen hundred eighty-seven shall not be implemented until April first, nineteen hundred ninety-five and shall be made prospectively for rates of payment issued effective April first, nineteen hundred ninety-five including the impact of such adjustment for the period January first, nineteen hundred ninety-five through March thirtieth, nineteen hundred ninety-five.

(g) Notwithstanding any other provisions of this section, all costs and statistics that are related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) shall not be included in the establishment of any payment rates computed in accordance with the provisions of this section.

(i) Unless provided otherwise in specific provisions included in this section, the exclusion of costs which are related to routine inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by title XVIII of the federal social security act (medicare) shall be based on the nineteen hundred eighty-five inpatient days actually paid on behalf of beneficiaries of title XVIII of the federal social security act (medicare) plus any days for such beneficiaries not paid on the basis of a decision by a review agent that the days were unnecessary. Ancillary costs related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by title XVIII of the federal social security act (medicare) shall be excluded on the basis of the nineteen hundred eighty-five cost center ratio of hospital ancillary inpatient service charges related to such beneficiaries to total hospital cost center inpatient ancillary services charges applied to cost center costs. Inpatient malpractice insurance costs which are attributable to title XVIII of the federal social security act (medicare) shall be excluded based on the methodology employed by title XVIII of the federal social security act (medicare) to identify such

costs.

(ii) Costs and statistics related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by a secondary payor shall be excluded in accordance with rules and regulations adopted by the council and approved by the commissioner in the determination of case payment rates computed in accordance with the provisions of this section.

(h)(i) Any malpractice insurance costs which are the result of general hospitals having to purchase or provide excess malpractice insurance coverage for physicians in accordance with section nineteen of chapter two hundred ninety-four of the laws of nineteen hundred eighty-five or section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended shall not be included in calculating malpractice insurance costs for purposes of paragraph (e) of subdivision one of this section.

(ii) The component of general hospital reimbursable inpatient operating costs based on the general hospital's inpatient malpractice insurance costs plus the component of special additional inpatient operating costs determined in accordance with subparagraphs (i) and (iii) of paragraph (e) of subdivision one of this section specifically related to inpatient malpractice insurance costs used to determine payment rates for annual rate periods beginning on or after January first, nineteen hundred eighty-eight shall be allocated among the payors in accordance with regulations adopted by the council and approved by the commissioner.

(i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, the payment rate shall be increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent. This paragraph shall not apply to payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, the comprehensive motor vehicle insurance reparations act, the terms of any

personal injury liability insurance policy, marine and inland marine insurance policy or marine protections and indemnity insurance policy.

(j) No operating cost ceilings or disallowances other than those applicable for purposes of the determination of a general hospital's reimbursable inpatient operating cost base in accordance with paragraph (d) of subdivision one of this section shall be applied to general hospitals, except for any cost ceilings or disallowances applied for purposes of subdivision twenty-four of this section and cost disallowances for general hospitals with rates based on budgeted costs.

(k) Notwithstanding any inconsistent provision of this section, case based rates of payment per discharge may, in accordance with rules and regulations adopted by the council and approved by the commissioner, reflect incorporation of severity of illness considerations in the methodology to determine such rates of payment.

(l) Notwithstanding any inconsistent provision of this section, nothing in this section shall preclude a modification to case based rates of payment per discharge in accordance with rules and regulations adopted by the council and approved by the commissioner to reflect readmission of an individual or unnecessary multiple admissions of an individual to a general hospital or general hospitals.

(m) Notwithstanding any inconsistent provision of this section, a general hospital that exceeded maximum charge limitations as determined by the commissioner in the rate periods nineteen hundred eighty-four through nineteen hundred eighty-seven may be authorized in accordance with rules and regulations adopted by the council and approved by the commissioner to reduce payments determined pursuant to this section in order to effect a reduction equivalent to such amount by which such general hospital exceeded maximum charge limitations.

(n) (i) For a patient discharged from a general hospital on or after August first, nineteen hundred eighty-eight and covered by a payor included in the payor categories specified in paragraph (a) or (b) of subdivision one of this section that provides for a percentage coinsurance responsibility by or on behalf of such patient for covered hospital services: (A) the dollar value of such percentage coinsurance responsibility by or on behalf of such patient shall be determined by multiplying such coinsurance percentage by the hospital's charges for such patient, determined in accordance with paragraph (c) of subdivision

one of this section or paragraph (e) of subdivision four of this section for a general hospital or distinct unit of a general hospital not reimbursed on case based payments, for the services covered by the payor, considering any applicable deductibles, and (B) the payment due to a general hospital for reimbursement of inpatient hospital services by such payor shall be determined by multiplying the payment rate determined in accordance with this section for such patient for covered hospital services by the coinsurance percentage for which such payor is responsible, considering any applicable deductibles.

(ii) A patient covered by a payor included in the payor categories specified in paragraph (a) or (b) of subdivision one of this section shall be deemed liable for the payment rate for inpatient hospital services for such patient for covered services determined in accordance with this section based on the rate of payment for such payor, provided, however, that for a patient discharged from a general hospital on or after August first, nineteen hundred eighty-eight a percentage coinsurance responsibility by or on behalf of such patient shall be deemed satisfied by payment of the dollar value of such percentage coinsurance responsibility determined in accordance with clause (A) of subparagraph (i) of this paragraph.

(o) No general hospital shall refuse to provide hospital services to a person presented or proposed to be presented for admission to such general hospital by a representative of a correctional facility or a local correctional facility as defined respectively in subdivisions four, fifteen and sixteen of section two of the correction law based solely on the grounds such person is an incarcerated individual of such correctional facility or local correctional facility. No general hospital may demand or request any charge for hospital services provided to such person in addition to the charges or rates authorized in accordance with this article, except for charges for identifiable additional hospital costs associated with or reasonable additional charges associated with security arrangements for such person.

(p)(i) Notwithstanding any inconsistent provision of law, a general hospital that provides an inpatient component of hospice care for persons eligible for payments to a hospice by a government agency made in accordance with subdivisions two and three of section four thousand twelve of this chapter shall be reimbursed for such inpatient services

by or on behalf of the hospice at a rate of payment no greater than the applicable rate of payment determined in accordance with subdivisions two and three of section four thousand twelve of this chapter for such hospice and no general hospital may charge for such inpatient services rendered an amount in excess of such applicable rate of payment.

(ii) Notwithstanding any inconsistent provision of law, a general hospital that provides in accordance with contractual arrangements between a hospice and such general hospital an inpatient component of hospice care for persons who are not eligible for payments to the hospice by a government agency made in accordance with subdivisions two and three of section four thousand twelve of this chapter or as beneficiaries of title XVIII of the federal social security act (medicare) shall be reimbursed for such inpatient services by or on behalf of the hospice in accordance with such contractual arrangements.

(q) A third-party payor specified in paragraph (a), (b) or (c) of subdivision one of this section, with the exception of governmental agencies, shall provide the general hospital with a remittance advice at the time payment or adjustment to such payment is made. Such remittance advice shall include the patient's name, date of service, admission or financial control number if available and diagnosis-related group classification number if applicable and if different than that billed by the hospital. Such remittance advice shall also include (i) the amount or percentage payable under the policy or certificate after deductibles, co-payments and any other reduction of the amount billed including deductions for prompt payment; and (ii) a specific explanation of any denial, reduction, or other reason including any other third-party payor coverage, for not providing full reimbursement of the amount claimed.

* (r) Notwithstanding any inconsistent provision of this section, for purposes of establishing rates of payment by state governmental agencies for general hospital inpatient services provided for discharges on or after April first, nineteen hundred ninety-five, the reimbursable base year inpatient administrative and general costs of a general hospital, which shall include but not be limited to reported administrative and general, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. For

the purposes of this paragraph, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each general hospital.

* NB Expired March 31, 2011

* (s) Notwithstanding any inconsistent provisions of this section, for the period July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-five million dollars in the aggregate to be allocated among those voluntary non-profit and private proprietary general hospitals which qualified for rate adjustments pursuant to this paragraph as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of the total funds allocated pursuant to this paragraph as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six.

* NB Expires December 31, 2029

(s-1) To the extent funds are available pursuant to the provisions of paragraph (s-2) of this subdivision and otherwise notwithstanding any inconsistent provision of law to the contrary, for the rate periods September first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, and April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars in the aggregate for each such rate period, allocated among those voluntary non-profit and private proprietary general hospitals which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such

general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-2) (i) Notwithstanding any inconsistent provision of law to the contrary, the following funds heretofore or hereinafter accumulated shall be transferred by the commissioner and credited to the credit of the state general fund medical assistance local assistance account in an aggregate amount equal to the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-1) of this subdivision:

(A) from pool reserves from statewide and regional pools established pursuant to sections twenty-eight hundred seven-a, twenty-eight hundred seven-c, and twenty-eight hundred eight-c of this article;

(B) from unobligated monies available pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article;

(C) from interest income derived from pools established pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-l and twenty-eight hundred seven-s of this article.

(ii) To the extent that funds available pursuant to the provisions of subparagraph (i) of this paragraph are insufficient to meet the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-1) of this subdivision, the following funds hereto or hereinafter accumulated may be transferred by the commissioner to the state general fund medical assistance local assistance account for the purposes set forth in subparagraph (i) of this paragraph:

(A) from unobligated monies available pursuant to paragraphs (g) and (j) of subdivision 1 of section twenty-eight hundred seven-l of this article;

(B) from unobligated monies available pursuant to clause (D) of subparagraph (ii) of paragraph (b) of subdivision one of section

twenty-eight hundred seven-1 of this article.

(iii) Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall transfer up to an additional two million dollars from the funding sources identified in subparagraph (i) of this paragraph to the state general fund. To the extent monies available from the funding sources identified in subparagraph (i) of this paragraph total less than two million dollars, the commissioner shall transfer monies from funding sources identified in subparagraph (ii) of this paragraph to the state general fund so that the total amount transferred pursuant to this provision equals two million dollars.

(s-3) To the extent funds are available pursuant to the provisions of paragraph (s-4) of this subdivision and otherwise notwithstanding any inconsistent provision of law to the contrary, for the rate period July first, nineteen hundred ninety-nine through March thirty-first, two thousand, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed thirty-six million dollars in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-4) Notwithstanding any inconsistent provision of law to the contrary, funds available pursuant to section 32-c of part F of the chapter of the laws of nineteen hundred ninety-nine which adds this paragraph shall be transferred by the commissioner and credited to the credit of the state general fund medical assistance local assistance account in an aggregate amount equal to the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-3) of this subdivision.

* (s-5) To the extent funds are available pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-v of this article and otherwise notwithstanding any inconsistent provision of law, for rate periods April first, two thousand through March thirty-first, two thousand three, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

* NB Expires December 31, 2029

(s-6) To the extent funds are available otherwise notwithstanding any

inconsistent provision of law to the contrary, for rate periods April first, two thousand three through March thirty-first, two thousand five, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven. These payments may be added to rates of payment or made as aggregate payments to eligible hospitals.

(s-7) To the extent funds are available otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods April first, two thousand five through March thirty-first, two thousand seven, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of April first, two thousand five under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen

hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-8) To the extent funds are available and otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods on and after April first, two thousand seven through November thirtieth, two thousand nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed sixty million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit general hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have medicaid inpatient discharges percentages equal to or greater than thirty-five percent. This percentage shall be computed based upon data reported to the department in each hospital's two thousand four institutional cost report, as submitted to the department on or before January first, two thousand seven. The rate adjustments calculated in accordance with this paragraph shall be allocated proportionally based on each eligible hospital's total reported medicaid inpatient discharges in two thousand four, to the total reported medicaid inpatient discharges for all such eligible hospitals in two thousand four, provided, however, that such rate adjustments shall be subject to reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation to the extent allowable under federal law. Such payments may be added to rates of payment or made as aggregate payments to eligible hospitals, provided,

however, that subject to the availability of federal financial participation and solely for the period April first, two thousand seven through March thirty-first, two thousand eight, six million dollars in the aggregate of this sixty million dollars shall be allocated to voluntary non-profit hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have Medicaid inpatient discharge percentages of less than thirty-five percent and which had previously qualified for distributions pursuant to paragraph (s-7) of this subdivision. The rate adjustment calculated in accordance with this paragraph shall be allocated proportionally based on the amount of money the hospital had received in two thousand six.

12. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter for patient services rendered shall not exceed the rates of payment approved by the commissioner for payments by such article forty-three insurance law corporations or article forty-four organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article nine-c insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the payments established by such hospital for patient services in accordance with the provisions of paragraph (c) of subdivision one of this section, or in the event the article forty-three insurance law corporation or

comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter provides for reimbursement on an expense incurred basis and makes payment directly to such hospital for patient services for its subscribers or beneficiaries, such article forty-three insurance law corporation or comprehensive health services plan shall be an additional category of payor of inpatient hospital services whose rates of payment are determined in accordance with paragraph (b) of subdivision one of this section based on an imputed rate of payment determined in accordance with paragraph (a) of subdivision one of this section for an article forty-three insurance law corporation, adjusted for uncovered services, and increased by thirteen percent.

(b) Any general hospital which had notified in writing an article nine-c corporation or a comprehensive health services plan prior to June first, nineteen hundred seventy-eight of its intention to terminate its contract with such corporation or plan in accordance with the terms of such contract, except a general hospital subject to the provisions of paragraph (a) of this subdivision may not charge a subscriber or beneficiary of a contract entered into pursuant to the provisions of article forty-three of the insurance law, or a member of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, after the effective date of termination of such contract, amounts in excess of the payments established by such hospital for patient services in accordance with the provisions of paragraph (c) of subdivision one of this section, or in the event the article forty-three insurance law corporation or comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter provides for reimbursement on an expense incurred basis and makes payment directly to such hospital for patient services for its subscribers or beneficiaries, such article forty-three insurance law corporation or comprehensive health services plan shall be an additional category of payor of inpatient hospital services whose rates of payment are determined in accordance with paragraph (b) of subdivision one of this section based on an imputed rate of payment determined in accordance with paragraph (a) of subdivision one of this section for an article forty-three insurance law corporation, adjusted for uncovered services, and increased by thirteen percent.

(c) No general hospital shall refuse to provide patient services to such subscribers or beneficiaries solely on the grounds of such subscription or membership.

(d) The provisions of this subdivision shall also apply to payments to general hospitals by a corporation organized and operating in accordance with article forty-three of the insurance law for inpatient and outpatient services on behalf of subscribers of a foreign corporation which performs similar functions in another state or which belongs to a national association comprised of similar corporations to which the article forty-three corporation also belongs; provided, however, the foreign corporation or the laws of the state in which the foreign corporation is organized extends to article forty-three corporations organized and operating in this state a reciprocal right to have the foreign corporation make payments to hospitals in that other state on behalf of subscribers of the article forty-three corporations at the same rate of payment as that foreign corporation pays for its own subscribers.

* (e) The provisions of this subdivision shall not apply to patients discharged on or after January first, nineteen hundred ninety-seven.

* NB Expires December 31, 2029

13. Restitution authorization. In enforcing the provisions of subdivisions one and twelve of this section, the commissioner may, in addition to the penalties and injunctions set forth in section twelve of this chapter, order that any general hospital provide restitution for any overpayments made by any party. Any hospital may request a formal hearing pursuant to the provisions of section twelve-a of this chapter in the event the hospital objects to any order of the commissioner hereunder. The commissioner may direct that such a hearing be held without any request by a hospital.

14. Bad debt and charity care allowance. * (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges, including rates of payment for state governmental agencies provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for

beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowance provided herein as a component of such payments are granted, established for rate periods commencing on or after January first, nineteen hundred eighty-eight and prior to January first, nineteen hundred ninety-seven in accordance with this section shall include the allowance specified in paragraph (c) of this subdivision. The allowance shall be computed on the basis of the operating and capital related components of such rates after trending of the operating portion. For the purposes of this subdivision and subdivision seventeen of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

* NB Effective until December 31, 2029

* (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges, including rates of payment for state governmental agencies provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowance provided herein as a component of such payments are granted, established for rate periods commencing on or after January first, nineteen hundred eighty-eight in accordance with this section shall include the allowance specified in paragraph (c) of this subdivision. The allowance shall be computed on the basis of the operating and capital related components of such rates after trending of the operating portion. For the purposes of this subdivision and subdivision seventeen of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million

dollars.

* NB Effective December 31, 2029

(b) The allowance shall be a percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision sixteen of this section, and within a statewide determination of financial resources to be committed for this purpose.

Need shall be defined as inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospital from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. Funds received by major public general hospitals pursuant to article forty-one of the mental hygiene law shall be considered to have been provided for inpatient hospital deficits only. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable hospitals to fairly and accurately determine and report losses from bad debts and the costs of charity care.

(c) The regional amounts to be included in rates approved for the rate year commencing January first, nineteen hundred eighty-eight shall be equal to the sum of the following two components divided by the total reimbursable inpatient costs for the general hospitals located in the region, excluding inpatient costs related to beneficiaries of title XVIII of the federal social security act (medicare), and after application of the trend factor. The first component shall be the result of the ratio between the total nominal payment amount in dollars as determined in subparagraph (i) of this paragraph that would be allocated to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals in the region based on a targeted need formula applied in accordance with subparagraphs (i) and (ii) of this paragraph and the statewide sum of such nominal payment amounts to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals applied to the total

statewide resources committed for this purpose to regional pools in the rate year, excluding the total statewide amount allocated in the rate year for this purpose to major public general hospitals in accordance with subparagraph (iii) of this paragraph. The second component shall be the dollar amount allocated to major public general hospitals in the region in accordance with subparagraph (iii) of this paragraph. The regional amount to be included in the rates approved for the rate years commencing on or after January first, nineteen hundred eighty-nine shall be computed in the same manner except that the base year for the targeted need as specified in subparagraph (i) of this paragraph shall be the calendar year which is two years prior to the rate year. For each annual rate period commencing on or after January first, nineteen hundred eighty-eight, the statewide amount to be available in regional pools for this purpose shall equal five and forty-eight hundredths percent of the total hospital reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor.

(i) Targeted need shall be defined as the relationship of need to net patient service revenue expressed as a percentage. Net patient service revenue shall be defined as net patient revenue attributable to inpatient and outpatient services excluding referred ambulatory services. For the rate year beginning January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred eighty-eight the scale specified in subparagraph (ii) of this paragraph shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their nineteen hundred eighty-six need and nineteen hundred eighty-six net patient service revenues. The nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in subparagraph (ii) of this paragraph. The sum of the nominal payment amounts for all hospitals in a region shall be the region's total nominal payment amount.

(ii) The scale utilized for development of each hospital's nominal

payment amount shall be as follows:

Targeted Need Percentage		Percentage of Reimbursement Attributable to that Portion of Targeted Need
0	-1%	35%
1+	-2%	50%
2+	-3%	65%
3+	-4%	85%
4+	-5%	90%
5%+		95%

(iii) The dollar amount allocated to major public general hospitals in a region in the rate years nineteen hundred eighty-eight, nineteen hundred eighty-nine and in that portion of the nineteen hundred ninety rate year beginning on January first and ending on June thirtieth shall be one hundred two percent and in that portion of the nineteen hundred ninety rate year beginning on July first and ending on December thirty-first, and in subsequent rate years shall be one hundred ten percent of the result of the application of the ratio of the major public general hospitals' inpatient reimbursable costs within the region to total statewide general hospital inpatient reimbursable costs, as computed on the basis of nineteen hundred eighty-five financial and statistical reports and excluding costs related to services to beneficiaries of title XVIII of the federal social security act (medicare), to the statewide resources committed for this purpose to regional pools, computed without consideration of inpatient uncollectible amounts.

(iv) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five the allowance pursuant to this subdivision shall be a uniform regional allowance percentage of five and forty-eight hundredths percent for all regions.

(d) In the event the regional percentage bad debt and charity care allowances for general hospitals for a rate period commencing on or after January first, nineteen hundred ninety-four determined in accordance with paragraph (c) of this subdivision to be submitted to bad debt and charity care regional pools established pursuant to subdivision sixteen of this section and deposited in accordance with subdivision seventeen of this section do not qualify for waiver pursuant to federal

law and regulation related to such regional allowance variations, in order for such allowances to be qualified as a broad-based health care related tax for purposes of the revenues received by the state from such allowances not reducing the amount expended by the state as medical assistance for purposes of federal financial participation, but the regional percentage allowances for the nineteen hundred ninety-three rate year do so qualify, then the regional percentage allowances for the regions for the nineteen hundred ninety-three rate year determined in accordance with paragraph (c) of this subdivision shall be further continued for such period for such regions.

14-a. Supplementary bad debt and charity care adjustment. (a) Notwithstanding any inconsistent provision of this section, rates of payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period April first, nineteen hundred eighty-nine to December thirty-first, nineteen hundred eighty-nine and for each annual period commencing January first during the period January first, nineteen hundred ninety to December thirty-first, nineteen hundred ninety-three applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section for a major public general hospital, as defined in paragraph (a) of subdivision fourteen of this section, shall include a supplementary bad debt and charity care adjustment determined in accordance with paragraph (b) of this subdivision provided the state governmental agency or the county government in which such general hospital is located, or the city of New York for a general hospital operated by the New York city health and hospitals corporation, files in such time and manner as may be specified by the commissioner an election for such adjustment for such hospital for each period provided that such election is subject to the approval of the state director of the budget and provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted.

(b)(i) A supplementary bad debt and charity care adjustment for the period April first, nineteen hundred eighty-nine to December thirty-first, nineteen hundred eighty-nine and for each annual period commencing January first during the period January first, nineteen hundred ninety to December thirty-first, nineteen hundred ninety-three for an eligible major public general hospital shall be determined for each period in accordance with rules and regulations adopted by the council and approved by the commissioner based upon the amount calculated by subtracting the amount projected to be distributed to such major public general hospital pursuant to paragraph (a) of subdivision seventeen of this section for such period from an amount calculated as the product of the projected bad debt and charity care nominal payment amount coverage ratio for such period for voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals multiplied by the base year bad debt and charity care imputed nominal payment amount for such major public general hospital determined in accordance with the methodology provided in paragraph (c) of subdivision fourteen of this section for calculation of a nominal payment amount for voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals. The coverage ratio shall be computed as the ratio between the sum of the dollar value of the amount committed to the regional pools in accordance with paragraph (c) of subdivision fourteen of this section and paragraph (a) of subdivision nineteen of this section for the rate period that would be allocated to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals in accordance with paragraph (b) of subdivision seventeen of this section and the base year nominal payment amount for such hospitals.

(ii) A supplementary bad debt and charity care adjustment provided in accordance with subparagraph (i) of this paragraph shall be adjusted to reflect actual distributions pursuant to paragraph (a) and (b) of subdivision seventeen of this section.

* (c) Notwithstanding any inconsistent provision of this subdivision, a supplementary bad debt and charity care adjustment shall be determined and provided for each of the nineteen hundred ninety-four, nineteen hundred ninety-five and nineteen hundred ninety-six rate periods, provided that the election pursuant to paragraph (a) of this subdivision

is continued for such period, for a major public general hospital equal to the higher of such adjustment for the nineteen hundred ninety-one rate period or for the nineteen hundred ninety-three rate period. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective until December 31, 2029

* (c) Notwithstanding any inconsistent provision of this subdivision, a supplementary bad debt and charity care adjustment shall be determined and provided for each of the nineteen hundred ninety-four, nineteen hundred ninety-five and for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six rate periods, provided that the election pursuant to paragraph (a) of this subdivision is continued for such period, for a major public general hospital equal to the higher of such adjustment for the nineteen hundred ninety-one rate period or for the nineteen hundred ninety-three rate period. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective December 31, 2029

* (d) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a), (b) and (c) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

* NB Expires December 31, 2029

14-b. General health care services allowance. (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges established for rate periods commencing on or after January first, nineteen hundred ninety-one in accordance with this section shall include a percentage allowance of the general hospital's reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor, as follows:

(i) for the nineteen hundred ninety-one, nineteen hundred ninety-two and nineteen hundred ninety-three rate periods, an allowance of

twenty-three hundredths of one percent;

(ii) for the nineteen hundred ninety-four rate period, an allowance of six hundred fourteen thousandths of one percent;

(iii) for the January first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-five rate period, an allowance of six hundred thirty-seven thousandths of one percent;

(iv) for the July first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five rate period, an allowance of one and forty-two hundredths percent; and

* (v) for the January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six rate period, an allowance of one and nine hundredths percent.

* NB Effective until December 31, 2029

* (v) for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six rate period, an allowance of one and nine hundredths percent.

* NB Effective December 31, 2029

(b) For rate periods beginning on or after January first, nineteen hundred ninety-one but prior to January first, nineteen hundred ninety-four, funds will be accumulated and made available in regional pools created by the commissioner for regional distributions in accordance with section twenty-eight hundred seven-bb of this chapter through the submission by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision. Such regions shall be those established pursuant to paragraph (b) of subdivision sixteen of this section. The regional pools may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments by or on behalf of general hospitals to regional pools shall be due and arrearages shall be treated in accordance with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools.

(c) If on September thirtieth, nineteen hundred ninety-four, any funds accumulated over the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three are unused or uncommitted for the allocations provided for in this subdivision, such unused or uncommitted funds shall be reallocated for use in

accordance with the provisions of subdivision seventeen of this section.

(d) For the rate periods commencing on or after January first, nineteen hundred ninety-four, funds will be accumulated in a statewide pool created by the commissioner through the submission by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision, for distributions in accordance with subdivision nineteen-a of this section.

(e) The commissioner is authorized to contract with a pool administrator designated in accordance with paragraph (c) of subdivision sixteen of this section or, if not available, such other administrators as the commissioner shall designate, to receive funds for the pools created pursuant to this subdivision and to distribute funds in accordance with this subdivision and subdivision nineteen-a of this section. If a pool administrator is designated, the commissioner shall conduct or cause to be conducted an annual audit of the receipt and distribution of pool funds. The reasonable costs and expenses of a pool administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars, shall be paid from the pooled funds.

(f) (i) Payments to the pools by or on behalf of general hospitals of funds due based on the allowances provided in accordance with this subdivision shall be due in accordance with the provisions of subdivision twenty of this section in the same manner as applicable to bad debt and charity care regional pools. Arrearages in payments due may be collected and interest and penalties due shall be determined and may be collected by the commissioner in accordance with the provisions of subdivision twenty of this section in the same manner as applicable to bad debt and charity care regional pools.

(ii) Notwithstanding any inconsistent provision of this section, as shall be necessary to obtain federal financial participation in medical assistance expenditures in accordance with title XIX of the federal social security act, the allowances included in rates of payment pursuant to this subdivision on behalf of patients eligible for medical assistance pursuant to title eleven of article five of the social services law shall be withheld from medical assistance payments to general hospitals and paid to pools on behalf of the general hospitals where a general hospital elects such withholding in such time and manner

as specified by the commissioner, and in the event a general hospital does not elect such withholding, payments by such general hospital to a pool based on an allowance received for medical assistance patients shall be due within five days of receipt of such funds. Funds withheld by a payor and paid to a pool on behalf of a general hospital shall be considered received by such general hospital and paid to the pool by such general hospital for all purposes.

(g) The allowances provided pursuant to paragraph (a) of this subdivision shall be effective and implemented for purposes of determining rates of payment for state governmental agencies contingent on receipt of all federal approvals necessary by federal law or regulations for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon such allowances as a component of such payments. If such federal approvals are not granted for such allowances or components thereof, rates of payment for state governmental agencies shall be determined in accordance with the provisions of this section without consideration of such allowances or such components plus an adjustment not subject to federal financial participation equal to one-half of the difference between such rates of payment determined without consideration of such allowances or components and a rate of payment determined based on such allowances or components. The pools established pursuant to this subdivision shall refund to the state governmental agency from pool reserves, current funds or future receipts any overpayment received based on a retroactive reduction pursuant to this paragraph in the allowances.

(h) The allowances provided pursuant to paragraph (a) of this subdivision or components thereof shall be of no force and effect and shall be deemed to have been null and void as of January first, nineteen hundred ninety-four in the event the secretary of the department of health and human services determines that such allowances or such components thereof are an impermissible health care related tax for purposes of the federal medicaid voluntary contribution and provider-specific tax amendments of nineteen hundred ninety-one for purposes of such funds reducing the amount deemed expended by the state as medical assistance for purposes of federal financial participation.

14-c. Bad debt and charity care allowance for financially distressed hospitals. * (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges established for rate periods commencing on or after January first, nineteen hundred ninety-one but prior to January first, nineteen hundred ninety-four in accordance with this section shall include an allowance of two hundred thirty-five thousandths of one percent; and for the rate periods during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six an allowance of three hundred twenty-five thousandths of one percent of the general hospital's reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor.

* NB Effective until December 31, 2029

* (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges established for rate periods commencing on or after January first, nineteen hundred ninety-one but prior to January first, nineteen hundred ninety-four in accordance with this section shall include an allowance of two hundred thirty-five thousandths of one percent; and for the rate periods during the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six an allowance of three hundred twenty-five thousandths of one percent of the general hospital's reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor.

* NB Effective December 31, 2029

(b) A statewide pool shall be created through the submissions by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision. Funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent

of funds appropriated therefor, funds shall be made available for distributions by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from the statewide pool in the same manner as distributions made in accordance with paragraph (c) of subdivision nineteen of this section. The statewide pools may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments by or on behalf of general hospitals to statewide pools shall be due and arrearages, interest and penalties shall be treated in accordance with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools.

(c) Notwithstanding any inconsistent provision of law, the commissioner may allocate and distribute funds accumulated in the statewide pool created pursuant to this subdivision and funds accumulated in the statewide pool created by the assessments authorized in accordance with subdivision eighteen of this section and available for distribution in accordance with paragraphs (c) and (d) of subdivision nineteen of this section for contracts for independent management audits of financially distressed hospitals, provided, however, that the total amount for audits pursuant to this paragraph shall not exceed two million five hundred thousand dollars over the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-five. Copies of management audit reports of financially distressed hospitals shall be provided by the commissioner to the chairs of the senate and assembly health committees.

14-d. Supplementary low income patient adjustment. * (a) Notwithstanding any inconsistent provision of this section, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-six applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible general hospitals a supplementary low

income patient adjustment determined in accordance with paragraph (b) of this subdivision, provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective until December 31, 2029

* (a) Notwithstanding any inconsistent provision of this section, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for rate periods during the period January first, nineteen hundred ninety-one through June thirtieth, nineteen hundred ninety-six applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible general hospitals a supplementary low income patient adjustment determined in accordance with paragraph (b) of this subdivision, provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective December 31, 2029

* (b) A supplementary low income patient adjustment for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three shall be determined, subject to the provisions of subparagraph (iv) of this paragraph, and for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six shall be determined for each eligible hospital according to the scale specified in subparagraph (iii) of this paragraph based upon the amount calculated by multiplying the applicable supplemental percentage coverage of need amount for the hospital by the hospital's need as defined in paragraph (b) of subdivision fourteen of this section; provided, however, that for the

period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six if the sum of the adjustments pursuant to clause (C) of subparagraph (iii) of this paragraph would exceed thirty-six million dollars for a rate year on an annualized basis the supplemental percentage coverage of need scale pursuant to clause (C) of subparagraph (iii) of this paragraph shall be reduced on a pro rata basis so that the sum of such adjustments provided for the rate year on an annualized basis shall not exceed thirty-six million dollars.

(i) The low income patient percentage of a general hospital shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical assistance pursuant to title eleven of article five of the social services law plus inpatient discharges of self-pay patients plus inpatient discharges of charity care patients divided by total inpatient discharges expressed as a percentage. For the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the percentages shall be calculated based on base year nineteen hundred eighty-nine, received by the department no later than November first, nineteen hundred ninety, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. For the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six, the percentages shall be calculated based on base year nineteen hundred ninety-one, received by the department no later than November first, nineteen hundred ninety-three, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. In order to be eligible for an adjustment pursuant to this subdivision, a hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(ii) For the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, hospital need shall be calculated based on base year nineteen hundred eighty-nine data. For the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six, hospital need shall be calculated based on base year nineteen hundred ninety-one data.

(iii)(A) The scale utilized for development of a hospital's

supplementary low income patient adjustment shall be as follows for the period January first, nineteen hundred ninety-one through June thirtieth, nineteen hundred ninety-one:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
50+	55%	5%
55+	60%	10%
60+	65%	15%
65+	70%	22.5%
70+	75%	30%
75+	80%	37.5%
80+		45%

(B) The scale utilized for development of a hospital's supplementary low income adjustment shall be as follows for the period July first, nineteen hundred ninety-one for a public general hospital through December thirty-first, nineteen hundred ninety-six and for a voluntary non-profit or a private proprietary general hospital through September thirtieth, nineteen hundred ninety-two:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
35+	55%	20%
55+	60%	25%
60+	65%	30%
65+	70%	37.5%
70+		45%

(C) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment shall be as follows for the period October first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three and for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
35+	50%	10%
50+	55%	20%
55+	60%	25%
60+	65%	30%

65+ 70%

37.5%

70+

45%

(D) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period May fifteenth, nineteen hundred ninety-three through December thirty-first, nineteen hundred ninety-three shall be at one hundred twenty percent of the supplemental percentage coverage of need scale specified in clause (C) of this subparagraph.

(iv) A supplementary low income patient adjustment determined according to the scale specified in subparagraph (iii) of this paragraph shall be limited for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three such that the amount of such adjustment for an eligible hospital, plus the amount committed to the regional pools in accordance with paragraph (c) of subdivision fourteen of this section and paragraph (a) of subdivision nineteen of this section for the rate period that would be allocated to such hospital, plus, if applicable, any distribution for the rate period pursuant to paragraph (d) of subdivision nineteen of this section for such hospital, and plus for a major public general hospital the amount of any supplementary bad debt and charity care adjustment provided pursuant to subdivision fourteen-a of this section for the rate period shall not exceed ninety percent of need.

(v) The provisions of this subdivision shall not apply to a general hospital eligible for distributions made pursuant to paragraph (c) of subdivision nineteen of this section.

* NB Effective until December 31, 2029

* (b) A supplementary low income patient adjustment for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three shall be determined, subject to the provisions of subparagraph (iv) of this paragraph, and for the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six shall be determined for each eligible hospital according to the scale specified in subparagraph (iii) of this paragraph based upon the amount calculated by multiplying the applicable supplemental percentage coverage of need amount for the hospital by the hospital's need as defined in paragraph (b) of

subdivision fourteen of this section; provided, however, that for the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six if the sum of the adjustments pursuant to clause (C) of subparagraph (iii) of this paragraph would exceed thirty-six million dollars for a rate year on an annualized basis the supplemental percentage coverage of need scale pursuant to clause (C) of subparagraph (iii) of this paragraph shall be reduced on a pro rate basis so that the sum of such adjustments provided for the rate year on an annualized basis shall not exceed thirty-six million dollars.

(i) The low income patient percentage of a general hospital shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical assistance pursuant to title eleven of article five of the social services law plus inpatient discharges of self-pay patients plus inpatient discharges of charity care patients divided by total inpatient discharges expressed as a percentage. For the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the percentages shall be calculated based on base year nineteen hundred eighty-nine, received by the department no later than November first, nineteen hundred ninety, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. For the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six, the percentages shall be calculated based on base year nineteen hundred ninety-one, received by the department no later than November first, nineteen hundred ninety-three, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. In order to be eligible for an adjustment pursuant to this subdivision, a hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(ii) For the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, hospital need shall be calculated based on base year nineteen hundred eighty-nine data. For the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six, hospital need shall be calculated based on base year nineteen hundred ninety-one data.

(iii)(A) The scale utilized for development of a hospital's supplementary low income patient adjustment shall be as follows for the period January first, nineteen hundred ninety-one through June thirtieth, nineteen hundred ninety-one:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
50+	55%	5%
55+	60%	10%
60+	65%	15%
65+	70%	22.5%
70+	75%	30%
75+	80%	37.5%
80+		45%

(B) The scale utilized for development of a hospital's supplementary low income adjustment shall be as follows for the period July first, nineteen hundred ninety-one for a public general hospital through June thirtieth, nineteen hundred ninety-six and for a voluntary non-profit or a private proprietary general hospital through September thirtieth, nineteen hundred ninety-two:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
35+	55%	20%
55+	60%	25%
60+	65%	30%
65+	70%	37.5%
70+		45%

(C) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment shall be as follows for the period October first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three and for the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six:

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need
35+	50%	10%
50+	55%	20%
55+	60%	25%

60+	65%	30%
65+	70%	37.5%
70+		45%

(D) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period May fifteenth, nineteen hundred ninety-three through December thirty-first, nineteen hundred ninety-three shall be at one hundred twenty percent of the supplemental percentage coverage of need scale specified in clause (C) of this subparagraph.

(iv) A supplementary low income patient adjustment determined according to the scale specified in subparagraph (iii) of this paragraph shall be limited for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three such that the amount of such adjustment for an eligible hospital, plus the amount committed to the regional pools in accordance with paragraph (c) of subdivision fourteen of this section and paragraph (a) of subdivision nineteen of this section for the rate period that would be allocated to such hospital, plus, if applicable, any distribution for the rate period pursuant to paragraph (d) of subdivision nineteen of this section for such hospital, and plus for a major public general hospital the amount of any supplementary bad debt and charity care adjustment provided pursuant to subdivision fourteen-a of this section for the rate period shall not exceed ninety percent of need.

(v) The provisions of this subdivision shall not apply to a general hospital eligible for distributions made pursuant to paragraph (c) of subdivision nineteen of this section.

* NB Effective December 31, 2029

(c) A supplementary low income patient adjustment provided in accordance with this subdivision for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three shall be adjusted to reflect actual distributions pursuant to paragraphs (a) and (b) of subdivision seventeen of this section and paragraph (d) of subdivision nineteen of this section and adjustments provided pursuant to subdivision fourteen-a of this section.

(d) Notwithstanding any inconsistent provision of law, a voluntary

non-profit or proprietary general hospital where the low income patient percentage, as determined in accordance with provisions of this subdivision, is between thirty-five and sixty-five percent shall be charged an assessment which for the period July first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one shall equal five percent of the general hospital's bad debt and charity care need as determined in accordance with paragraph (b) of subdivision fourteen of this section and for the period January first, nineteen hundred ninety-two through September thirtieth, nineteen hundred ninety-two shall equal seven and one-half percent of the general hospital's bad debt and charity care need as determined in accordance with paragraph (b) of subdivision fourteen of this section. Such assessment shall be paid to the commissioner or his designee prior to October first, nineteen hundred ninety-two in accordance with a schedule established by the commissioner. The assessments may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments of the assessments shall be due and arrearages shall be treated in accordance with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools. Funds accumulated shall be deposited by the commissioner and credited to the department of social services medical assistance program general fund - local assistance account appropriation.

* (e) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a) and (b) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

* NB Expires December 31, 2029

* 14-f. Public general hospital indigent care adjustment.

Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance

provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, provided, however, that for periods on and after January first, two thousand thirteen an annual amount of four hundred twelve million dollars shall be allocated to eligible major public hospitals based on each hospital's proportionate share of medicaid and uninsured losses to total medicaid and uninsured losses for all eligible major public hospitals, net of any disproportionate share hospital payments received pursuant to sections twenty-eight hundred seven-k and twenty-eight hundred seven-w of this article. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective until December 31, 2029

* 14-f. Public general hospital indigent care adjustment.

Notwithstanding any inconsistent provision of this section, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of

such payments are granted. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

* NB Effective and repealed December 31, 2029

15. Special provisions for payments by governmental agencies. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowance specified in paragraph (c) of subdivision fourteen of this section as a component of such payments is not approved by the federal government, rates of payment by governmental agencies for the operating cost component of general hospital inpatient services shall be increased for each hospital by the same percentage allowance as each hospital's federal fiscal year nineteen hundred eighty-seven disproportionate share payment adjustment factor for revenues received from services provided to beneficiaries of title XVIII of the federal social security act (medicare) as determined in accordance with the provisions of section eighteen hundred eighty-six-d of title XVIII of the federal social security act (medicare). Increased amounts received by general hospitals in accordance with the provision of this subdivision shall be offset against distributions to such hospitals that were made or would be made pursuant to the provisions contained in subdivisions seventeen and nineteen of this section. In the event that distributions had been made to such hospitals pursuant to such subdivisions, the hospital shall, on a proportional basis, return to the pool from which the distributions were made an amount equal to the increased amounts received under this subdivision to the extent that such increased amounts do not exceed distributions made. Funds in the statewide pool created in accordance with subdivision sixteen of this section, which would have been distributed in accordance with paragraph (c) of subdivision nineteen of this section if the provisions of this subdivision were not in effect, less any amounts not distributed as the result of the offset provisions of this subdivision shall be distributed to regional pools to the extent that such funds are available and necessary to maintain regional pool distributions, with consideration of the offset provisions in this subdivision, at the levels that would be available pursuant to the provisions of subdivision fourteen of this section if the provisions of

this subdivision did not apply.

16. Bad debt and charity care regional pools and bad debt and charity care and capital statewide pool, general. (a) Funds will be made available in bad debt and charity care regional pools created by the commissioner for distributions in accordance with subdivision seventeen of this section through the submissions by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (c) of subdivision fourteen of this section and through the transfer of funds available from the bad debt and charity care and capital statewide pool in accordance with paragraph (a) of subdivision nineteen of this section. Funds will be made available for distributions in accordance with subdivision nineteen of this section from a bad debt and charity care and capital statewide pool created by the commissioner through the submissions by general hospitals of the amount of the assessments authorized in accordance with subdivision eighteen of this section.

(b) The regions are established as the article forty-three insurance plan regions, with the exception that the southern sixteen counties shall be divided into three regions for the purposes of subdivisions fourteen and seventeen of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. Such regions shall be the same regions established and in effect January first, nineteen hundred eighty-five. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur.

(c) For periods prior to January first, two thousand five, the commissioner and the commissioner of social services are authorized to contract with the article forty-three insurance law plans, or if not available such other administrators as the commissioner and the commissioner of social services shall designate, to receive funds for the bad debt and charity care regional pools and/or the bad debt and charity care and capital statewide pool and distribute funds from such

pools. In the event contracts with the article forty-three insurance law plans or other commissioners' designees are effectuated, the commissioner and the commissioner of social services shall jointly conduct or cause to be conducted annual audits of the receipt and distribution of the pooled funds. The reasonable costs and expenses of a pool administrator as approved by the commissioner and the commissioner of social services, not to exceed for personnel services on an annual basis four hundred thousand dollars for all pools, shall be paid from the pooled funds. Such pool administrator or pool administrators shall be acting on behalf of the state medical assistance program provided pursuant to title eleven of article five of the social services law in the distribution to hospitals pursuant to subdivisions fourteen-c, seventeen and paragraphs (c) and (d) of subdivision nineteen of this section of pooled funds.

(d) In order for a general hospital to participate in the distribution of funds from the pools, the general hospital must implement collection policies and procedures approved by the commissioner.

(e) In order for a general hospital to be eligible for distribution of funds from the pools, such general hospital if it provides obstetrical care and services must agree to participate in a program approved by the department for the provision of prenatal care to persons eligible for medical assistance or medically indigent persons if requested by such a program. Nothing stated herein shall require a hospital to grant admitting privileges to a physician solely because such person is part of an approved program. The participation of hospitals in an approved program shall include, but not be limited to:

(i) arrangements with designated prenatal care providers for prebooking pregnant women for approximate delivery time, and provision of staff and facilities for the delivery and necessary postpartum care for women and infants involved in such programs;

(ii) a system for medical record transfer from a prenatal care provider to hospital staff participating in delivery and for the transfer of information regarding hospital delivery and care back to the prenatal care provider for postpartum follow-up; and

(iii) an agreement with designated prenatal care providers to accept the care of high risk patients on a referral basis and/or to provide special tests and procedures which are not ordinarily available to

prenatal care clinics if such hospital is capable of caring for high risk patients and/or providing special tests and procedures.

(f) The council may adopt regulations subject to the approval of the commissioner to allow advanced distributions from these pools to a general hospital qualifying for distributions in accordance with paragraph (c) of subdivision nineteen of this section, based on a demonstration by the hospital that there is an inability to finance current obligations and obtain needed working capital.

* (g) Notwithstanding any inconsistent provision of law to the contrary, from interest heretofore earned or hereinafter earned on funds in bad debt and charity care regional pools and the bad debt and charity care and capital statewide pool established pursuant to this section, such amounts as shall be necessary, within amounts appropriated, shall be reallocated to, and the state comptroller is hereby authorized and directed to receive for deposit to, the credit of the department of health's special revenue fund - other, hospital based grants program account, for purposes of services and expenses related to general hospital based grant programs for the period April first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six and for the period July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven.

* NB Effective until December 31, 2029

* (g) Notwithstanding any inconsistent provision of law to the contrary, from interest heretofore earned or hereinafter earned on funds in bad debt and charity care regional pools and the bad debt and charity care and capital statewide pool established pursuant to this section, such amounts as shall be necessary, within amounts appropriated, shall be reallocated to, and the state comptroller is hereby authorized and directed to receive for deposit to, the credit of the department of health's special revenue fund - other, hospital based grants program account, for purposes of services and expenses related to general hospital based grant programs for the period April first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six.

* NB Effective December 31, 2029

16-a. Pool administration, general. (a) If a general hospital fails to timely file a report with the department of funds due to a regional pool

or a statewide pool established pursuant to this section, the commissioner may estimate the amount due from such hospital based on available financial and statistical data and may collect in accordance with subdivision twenty of this section any amount due based on such estimate as a deficiency in payments to such regional pool or statewide pool with interest and penalties. The commissioner shall provide a general hospital with notice of any estimate of the amount due pursuant to this paragraph at least three days prior to collection of a deficiency by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

* (b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred seventy-four of the state finance law or any other law, at the discretion of the commissioner and the commissioner of social services without a competitive bid or request for proposal process, regional pool and statewide pool administration contracts in effect for rate year nineteen hundred ninety-three may be extended for administration of regional pools and statewide pools established for rate years nineteen hundred ninety-four and nineteen hundred ninety-five and nineteen hundred ninety-six to provide an uninterrupted continuation of services and may be amended as may be necessary.

* NB Effective until December 31, 2029

* (b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred seventy-four of the state finance law or any other law, at the discretion of the commissioner and the commissioner of social services without a competitive bid or request for proposal process, regional pool and statewide pool administration contracts in effect for rate year nineteen hundred ninety-three may be extended for administration of regional pools and statewide pools established for rate years nineteen hundred ninety-four and nineteen hundred ninety-five and for the rate period January first, nineteen hundred ninety six through June thirtieth, nineteen hundred ninety-six to provide an uninterrupted continuation of services and may be amended as may be necessary.

* NB Effective December 31, 2029

17. Bad debt and charity care regional pool distributions. Funds

accumulated in bad debt and charity care regional pools, including income from invested funds, from the allowance specified in paragraph (c) of subdivision fourteen of this section and funds accumulated in bad debt and charity care regional pools, including income from invested funds, from the transfer of funds available from the bad debt and charity care and capital statewide pool in accordance with paragraph (a) of subdivision nineteen of this section shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent of funds appropriated therefor, funds shall be made available for distribution by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from bad debt and charity care regional pools in accordance with the following methodology and sequence:

(a) For the nineteen hundred eighty-eight, nineteen hundred eighty-nine and for that portion of the nineteen hundred ninety rate year beginning on January first and ending on June thirtieth, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to one hundred two percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), developed on the basis of nineteen hundred eighty-five financial and statistical reports, to the total of all regional pools. For that portion of the nineteen hundred ninety rate year beginning on July first and ending on December thirty-first and in the annual rate years beginning on or after January first, nineteen hundred ninety-one, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to one hundred ten percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), developed on the basis of nineteen hundred eighty-five financial and statistical reports, to the total of all regional pools.

(b) (i) Funds remaining in the regional pools after distribution in accordance with paragraph (a) of this subdivision shall be distributed to voluntary non-profit, private proprietary and public general

hospitals, other than major public general hospitals, on the basis of each hospital's targeted need share. For the rate year beginning January first, nineteen hundred eighty-eight, an individual hospital's targeted need share shall be defined as the relationship between each hospital's nineteen hundred eighty-six nominal payment amount as defined in subparagraph (i) of paragraph (c) of subdivision fourteen of this section to the nineteen hundred eighty-six nominal payment amounts for all hospitals in the region other than major public general hospitals. For annual rate years beginning on or after January first, nineteen hundred eighty-nine, the base need shall be the calendar year which is two years prior to the rate year. The amount of funds to be distributed in accordance with this paragraph and paragraph (a) of this subdivision shall be limited to the amount of funds accumulated in the pools.

(ii) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five funds remaining in the regional pools after distribution in accordance with paragraph (a) of this subdivision shall be aggregated on a statewide basis and treated as a common pool for statewide distributions and distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of each hospital's targeted need share defined as the relationship between each hospital's base year nominal payment amount as defined in subparagraph (i) of paragraph (c) of subdivision fourteen of this section to the base year nominal payment amounts for all hospitals statewide other than major public general hospitals.

(d) The department may provide for interim payments to general hospitals of funds available for distribution from regional pools pursuant to this subdivision, subject to reasonable retainage for adjustments, subsequently reconciled to amounts due determined in accordance with this subdivision.

(e) Notwithstanding any inconsistent provision of this section, in the event funds available pursuant to paragraph (b-1) of subdivision nineteen of this section for programs to provide health care coverage for uninsured or underinsured children are inadequate to provide coverage to all eligible children for whom application for coverage is made in a rate period, such additional amounts not to exceed twenty-five million dollars for nineteen hundred ninety-four as shall be necessary

to provide such coverage shall be reserved by the commissioner from the amount to be available in bad debt and charity care regional pools for such rate period for additional distributions to such programs. Ten million dollars of the amount reserved for nineteen hundred ninety-four shall not result in a decrease to disproportionate share payments to hospitals.

18. Bad debt and charity care and capital statewide pool funding.

* The commissioner shall create a bad debt and charity care and capital statewide pool which shall be funded by a transfer of funds, which is hereby authorized, for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six and the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six equal to seven million five hundred thousand dollars for the nineteen hundred ninety-five period, three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period and three million seven hundred fifty thousand dollars for the July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six period to be submitted to a statewide pool, as designated by the commissioner, from the medical malpractice insurance association pursuant to section five thousand five hundred sixteen-c of the insurance law and through an assessment which shall be charged to general hospitals. In the event that the transfers of funds authorized by section five thousand five hundred sixteen-c of the insurance law do not occur by January first, nineteen hundred ninety-five, January first, nineteen hundred ninety-six and August first, nineteen hundred ninety-six respectively, the commissioner for each period for which such transfer from the medical malpractice insurance association has not occurred shall transfer seven million five hundred thousand dollars for the nineteen hundred ninety-five period, three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period and three million seven hundred fifty thousand dollars for the July first, nineteen hundred ninety-six through December

thirty-first, nineteen hundred ninety-six period from regional or statewide pool reserves for pools established pursuant to this section and section twenty-eight hundred eight-c or twenty-eight hundred seven-a of this article to the bad debt and charity care and capital statewide pool established pursuant to this subdivision. Such assessment shall be submitted to a statewide pool as designated by the commissioner and distributed on a monthly basis in accordance with subdivision twenty of this section. The assessment shall be:

- * NB Effective until December 31, 2029

- * The commissioner shall create a bad debt and charity care and capital statewide pool which shall be funded by a transfer of funds, which is hereby authorized, for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six equal to seven million five hundred thousand dollars for the nineteen hundred ninety-five period and three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period to be submitted to a statewide pool, as designated by the commissioner, from the medical malpractice insurance association pursuant to section five thousand five hundred sixteen-c of the insurance law and through an assessment which shall be charged to general hospitals. In the event that the transfers of funds authorized by section five thousand five hundred sixteen-c of the insurance law do not occur by January first, nineteen hundred ninety-five and January first nineteen hundred ninety-six respectively, the commissioner for each period for which such transfer from the medical malpractice insurance association has not occurred shall transfer seven million five hundred thousand dollars for the nineteen hundred ninety-five period and three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period from regional or statewide pool reserves for pools established pursuant to this section and section twenty-eight hundred eight-c or twenty-eight hundred seven-a of this article to the bad debt and charity care and capital statewide pool established pursuant to this subdivision. Such assessment shall be submitted to a statewide pool as designated by the commissioner

and distributed on a monthly basis in accordance with subdivision twenty of this section. The assessment shall be:

- * NB Effective December 31, 2029

- * (a) one and seventy-five thousandths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight; one and five hundredths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine; and one percent of each general hospital's gross revenue received for inpatient hospital services provided during annual periods beginning on or after January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety-nine and on or after January first, two thousand,

- * NB Effective until December 31, 2029

- * (a) one and seventy-five thousandths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight; one and five hundredths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine; and one percent of each general hospital's gross revenue received for inpatient hospital services provided during annual periods beginning on or after January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety-nine,

- * NB Effective and expires December 31, 2029

- * (a) one and seventy-five thousandths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight; one and five hundredths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine; and one percent of each

general hospital's gross revenue received for inpatient hospital services provided during annual rate periods beginning on or after January first, nineteen hundred ninety,

* NB Effective December 31, 2029

* (b) provided, however, subject to the provisions of paragraph (e) of this subdivision there shall be no assessment against those voluntary non-profit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of this section, or for the annual assessment period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of this section as of December thirty-first, nineteen hundred ninety-five, and

* NB Effective until December 31, 2029

* (b) provided, however, subject to the provisions of paragraph (e) of this subdivision there shall be no assessment against those voluntary non-profit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of this section, and

* NB Effective December 31, 2029

* (c) provided further, however, subject to the provisions of paragraph (e) of this subdivision the assessment against those voluntary non-profit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of this section as of December thirty-first, nineteen hundred ninety-five shall for the annual assessment period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight be abated in the amount of three-quarters of one percent of gross revenue received and for the annual assessment period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine be abated in the amount of one-quarter of one percent of gross revenue received.

* NB Effective until December 31, 2029

* (c) provided further, however, subject to the provisions of paragraph (e) of this subdivision the assessment against those voluntary non-profit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (b) of subdivision

sixteen of section twenty-eight hundred seven-a of this article during the nineteen hundred eighty-seven rate period or qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of this section during a rate period or rate periods but which do not continue to qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of this section during a rate period or rate periods shall for the initial rate period in which such general hospital does not continue to qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of this section be abated in the amount of two-thirds of one percent of gross revenue received and for the next succeeding annual rate period be abated in the amount of one-third of one percent of gross revenue received.

* NB Effective December 31, 2029

* (d) Gross revenue received shall mean all moneys received for or on account of inpatient hospital service, provided, however, that subject to the provisions of paragraph (e) of this subdivision gross revenue received shall not include distributions from bad debt and charity care regional pools, health care services pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with this section or distributions from funds allocated in accordance with section twenty-eight hundred seven-l, twenty-eight hundred seven-k, twenty-eight hundred seven-v or twenty-eight hundred seven-w of this article and shall not include the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c of this section, the adjustment provided in accordance with subdivision fourteen-a of this section, the adjustment provided in accordance with subdivision fourteen-d of this section, the adjustment for health maintenance organization reimbursement rates provided in accordance with former subdivision two-a of this section, payments made pursuant to paragraph (i) of subdivision thirty-five of this section or, if effective, the adjustment provided in accordance with subdivision fifteen of this section, the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended, revenue received from physician practice or faculty practice plan discrete billings for private practicing physician services, revenue from affiliation

agreements or contracts with public hospitals for the delivery of health care services at such public hospitals, revenue received as disproportionate share hospital payments in accordance with title nineteen of the federal social security act, or revenue from government deficit financing, provided, however, that funds received as medical assistance payments which include state share amounts authorized pursuant to section twenty-eight hundred seven-v of this article that are not disproportionate share hospital payments shall be included within the meaning of gross revenue for purposes of this subdivision.

* NB Effective until December 31, 2029

* (d) Gross revenue received shall mean all moneys received for or on account of inpatient hospital service, provided, however, that subject to the provisions of paragraph (e) of this subdivision gross revenue received shall not include distributions from bad debt and charity care regional pools, health care services pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with this section and shall not include the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c of this section, the adjustment provided in accordance with subdivision fourteen-a of this section, the adjustment provided in accordance with subdivision fourteen-d of this section, the adjustment for health maintenance organization reimbursement rates provided in accordance with subdivision two-a of this section, or, if effective, the adjustment provided in accordance with subdivision fifteen of this section or the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended.

* NB Effective December 31, 2029

(e) Each exclusion of hospitals or sources of gross revenue received from the assessments effective on or after October first, nineteen hundred ninety-two established pursuant to this subdivision shall be contingent upon either: (i) qualification of the assessments for waiver pursuant to federal law and regulation; or, (ii) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a

broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the assessments relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the assessments do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of October first, nineteen hundred ninety-two and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the hospital pays the retroactive amount due within ninety days of notice from the commissioner to the hospital that the exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner to the hospital.

(f) Payments of assessments and allowances required to be submitted by general hospitals pursuant to this subdivision and subdivisions fourteen and fourteen-b of this section and paragraph (a) of subdivision two of section twenty-eight hundred seven-d of this article shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by general hospitals with regard to subsequent payments, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such assessments and allowances which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year audit period, or from conducting an audit of any adjustment or reconciliation made by a general hospital within such six year period, or from conducting an audit of payments made prior to such six year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section. General hospitals which, in the course of such an audit, fail to produce data or documentation requested in furtherance of such an audit, within thirty days of such request may be assessed a civil penalty of up to ten

thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the hospital demonstrates good cause for such failure. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(g) If a general hospital fails to produce data or documentation requested in furtherance of an audit for a month to which an assessment applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of exemptions permitted pursuant to paragraph (d) of this subdivision cannot be determined from such available financial and statistical data the estimated amount due may be calculated on the basis of the general hospital's aggregate gross inpatient revenue amount, as determined from such available financial and statistical data for the year subject to audit. Estimated amounts due pursuant to this paragraph shall be paid by a general hospital within sixty days or within such other time period as agreed to by the commissioner and the facility. Thereafter the commissioner shall take all necessary steps to collect amounts owed pursuant to this paragraph, including by offsetting, or by directing the state comptroller to offset, such amounts due from any other payments made by state governmental agencies to the general hospital pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of paragraph (c) of subdivision twenty of this section.

(h) The commissioner shall take all necessary steps to collect delinquent amounts owed pursuant to this subdivision, including by recoupment or offsetting, or by directing the state comptroller to offset, such amounts due from any other payments made by state governmental agencies to the general hospital pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of paragraph (c) of subdivision twenty of this section. Delinquent amounts which have been referred for recoupment or offset pursuant to this paragraph, or which have been referred to the office of the attorney general for collection, shall be deemed final and not subject to further revision or reconciliation by the commissioner based on any additional reports or other information submitted by the hospital, provided, however, that such delinquencies shall not be

referred for such recoupment or for such collection based on estimated amounts unless the hospital has received written notification of such delinquencies and has been given no less than thirty days in which to submit delinquent reports.

(i) The commissioner may enter into agreements with general hospitals subject to this subdivision, in regard to which audit findings or prior settlements have been made pursuant to this subdivision, extending and applying such audit findings or prior settlements or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable to such subsequent un-audited periods when such amounts due as a result of such agreement, other than reduced or waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this subdivision, as referenced in such agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by hospitals subsequent to such agreements.

19. Bad debt and charity care and capital statewide pool distribution.

* Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision eighteen of this section for periods through December thirty-first, nineteen hundred ninety-six, including income from invested funds, shall be distributed or retained in accordance with the following sequence:

* NB Effective until December 31, 2029

* Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision eighteen of this section, including income from invested funds, shall be distributed or retained in accordance with the following sequence:

* NB Effective December 31, 2029

(a) Funds shall be distributed by the commissioner to bad debt and charity care regional pools established pursuant to subdivision sixteen

of this section to provide additional funds for distribution from such bad debt and charity care regional pools in accordance with subdivision seventeen of this section equal to the amount computed as the difference between the amount that would be available in such regional pools based on a statewide determination of financial resources to be committed to regional pools in each year in accordance with paragraph (c) of subdivision fourteen of this section based upon a percentage factor equal to five and ninety-three hundredths percent and the amount to be available in such regional pools based on a statewide determination of financial resources to be committed to regional pools in each year in accordance with paragraph (c) of subdivision fourteen of this section based upon a percentage factor equal to five and forty-eight hundredths percent.

* (b) An amount not to exceed seventeen million dollars on an annualized basis from the assessment through December thirty-first, nineteen hundred ninety-six may annually be placed in a statewide account in accordance with rules and regulations adopted by the council and approved by the commissioner for the purpose of securing financing of capital improvement projects for general hospitals qualifying for distributions made in accordance with paragraph (c) of this subdivision. Any reserved funds available on September first, nineteen hundred ninety-seven and not obligated, in accordance with section twelve of chapter nine hundred thirty-four of the laws of nineteen hundred eighty-five as amended, for the purpose of securing financing of capital improvement projects for general hospitals and any reserved funds that thereafter become available may be transferred by the commissioner, in consultation with the director of the budget and the dormitory authority, to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article or to the general hospital indigent care pool established pursuant to section twenty-eight hundred seven-k of this article.

* NB Effective until December 31, 2029

* (b) An amount not to exceed seventeen million dollars may annually be placed in a statewide account in accordance with rules and regulations adopted by the council and approved by the commissioner for the purpose of securing financing of capital improvement projects for general hospitals qualifying for distributions made in accordance with

paragraph (c) of this subdivision.

* NB Effective December 31, 2029

* (b-1) An amount equal to: twenty million dollars annually for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three; thirty million dollars for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four; thirty-seven million five hundred thousand dollars for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five; eighteen million seven hundred fifty thousand dollars for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six; and eighteen million seven hundred fifty thousand dollars for the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six shall annually be reserved and accumulated from year to year by the commissioner for distributions to programs to provide health care coverage for uninsured or underinsured children. Such accumulated funds shall not be used for any other purpose other than those authorized in section twenty-five hundred ten and twenty-five hundred eleven of this chapter. If on March thirty-first, nineteen hundred ninety-eight, any funds accumulated during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-seven are unused or uncommitted for such distributions, such unused or uncommitted funds shall be immediately transferred by the commissioner to the health care initiatives pool established by the commissioner to provide additional funds for distribution to programs to provide health care coverage for uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter. For cash flow purposes, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to this section such funds as shall be necessary not to exceed the amount authorized to be reserved annually to meet premium requirements pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for a rate year and shall refund such moneys when pool funds become available pursuant to this paragraph for such rate year.

* NB Effective until December 31, 2029

* (b-1) An amount equal to: twenty million dollars annually for the

period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three; thirty million dollars for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four; thirty-seven million five hundred thousand dollars for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five; and eighteen million seven hundred fifty thousand dollars for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six shall annually be reserved and accumulated from year to year by the commissioner for distributions to programs to provide health care coverage for uninsured or underinsured children. Such accumulated funds shall not be used for any other purpose other than those authorized in section twenty-five hundred ten and twenty-five hundred eleven of this chapter. If on September thirtieth, nineteen hundred ninety-seven, any funds accumulated during the period January first, nineteen hundred ninety-one through June thirtieth, nineteen hundred ninety-six are unused or uncommitted for such distributions, such unused or uncommitted funds shall be immediately transferred by the commissioner to bad debt and charity care regional pools established pursuant to subdivision sixteen of this section to provide additional funds for distribution from such bad debt and charity care regional pools in accordance with subdivision seventeen of this section. For cash flow purposes, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to this section such funds as shall be necessary not to exceed the amount authorized to be reserved annually to meet premium requirements pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for a rate year and shall refund such moneys when pool funds become available pursuant to this paragraph for such rate year.

* NB Effective December 31, 2029

(b-2) Funds available for distribution in accordance with paragraphs (c) and (d) of this subdivision shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent of funds appropriated therefor, funds shall be made available for distributions by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law from the bad

debt and charity care and capital statewide pool pursuant to paragraphs (c) and (d) of this subdivision.

(c) Funds shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance losses resulting from bad debts and the costs of charity care. Amounts to be distributed for bad debt and charity care purposes shall be determined after consideration of amounts to be distributed from regional pools in accordance with subdivision seventeen of this section and shall result in up to one hundred percent as defined in paragraph (b) of subdivision fourteen of this section being financed for these general hospitals.

(d) Funds shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-a of this article during the nineteen hundred eighty-seven rate period or qualified for distributions made in accordance with paragraph (c) of this subdivision during a rate period or rate periods but which do not continue to qualify for distributions made in accordance with paragraph (c) of this subdivision during a rate period or rate periods. Amounts to be distributed to a general hospital pursuant to this paragraph for the initial rate period in which such general hospital does not continue to qualify for distributions made in accordance with paragraph (c) of this subdivision shall be two-thirds of the amount such general hospital would have received in accordance with paragraph (c) of this subdivision for such initial rate period if the hospital had continued to be eligible for such distribution and for the next succeeding annual rate period one-third of the amount such general hospital would have received in accordance with paragraph (c) of this subdivision for such succeeding rate period.

(e) There shall be set aside within a transition account in the statewide pool, from accumulated funds, from the total allocation to the

bad debt and charity care and capital statewide pool of the assessment of one and seventy-five thousandths percent of gross revenue received in accordance with paragraph (a) of subdivision eighteen of this section for the rate period commencing January first, nineteen hundred eighty-eight and the assessment of one and five hundredths percent of gross revenue received in accordance with paragraph (a) of subdivision eighteen of this section for the rate period commencing January first, nineteen hundred eighty-nine an amount equal to seventy-five thousandths of one percent of gross revenue received and five hundredths of one percent of gross revenue received respectively to be distributed to voluntary non-profit, private proprietary and public general hospitals receiving less bad debt and charity care funds under the provisions of this section than if the provisions of section twenty-eight hundred seven-a of this article had applied using the same base year need as calculated in accordance with subdivision fourteen of this section. Rules for such distribution shall be those adopted by the council and approved by the commissioner.

(f) Any balance in the statewide pool shall be distributed in accordance with the following:

(i) Fifty percent of the balance shall be reserved and accumulated from year to year by the commissioner for distributions to regional pilot projects to provide health care coverage under insurance or equivalent mechanisms for uninsured or underinsured individuals and families and to provide health care coverage for catastrophic expenses provided legislation is enacted before July fifteenth, nineteen hundred eighty-eight authorizing such regional pilot projects and including an authorization for such regional pilot projects, notwithstanding any inconsistent provision of law, to negotiate special payment rate methodologies with general hospitals for inpatient hospital services.

(ii) * The remaining balance shall be reserved and accumulated from year to year by the commissioner for priority distributions in accordance with rules and regulations adopted by the council and approved by the commissioner: (A) to assist general hospitals in offsetting losses from bad debt and the costs of charity care in providing existing or expanded priority health services to the medically indigent or medically underserved in urban and rural areas including, but not limited to, services for pregnant women, services for children

under the age of six, and services related to acquired immune deficiency syndrome; (B) for quality assurance demonstration projects; (C) for severity of illness measurement demonstration projects; (D) for cost analyses and evaluations of health care provider services; (E) for quality improvement program grants and contracts pursuant to subdivision fifteen of section two hundred six of this chapter and department of health administrative costs related thereto; and (F) for initiatives to improve public health and to expand the availability of health care services.

* NB Effective until December 31, 2029

* The remaining balance shall be reserved and accumulated from year to year by the commissioner for priority distributions in accordance with rules and regulations adopted by the council and approved by the commissioner: (A) to assist general hospitals in offsetting losses from bad debt and the costs of charity care in providing existing or expanded priority health services to the medically indigent or medically underserved in urban and rural areas including, but not limited to, services for pregnant women, services for children under the age of six, and services related to acquired immune deficiency syndrome; (B) for quality assurance demonstration projects; (C) for severity of illness measurement demonstration projects; (D) for cost analyses and evaluations of health care provider services; and (E) for quality improvement program grants and contracts pursuant to subdivision fifteen of section two hundred six of this chapter and department of health administrative costs related thereto.

* NB Effective December 31, 2029

Notwithstanding any provision of law to the contrary, a sum not to exceed three million five hundred thousand dollars from funds available for distribution pursuant to this subparagraph may be allocated and distributed to regional pilot projects to provide health care coverage under insurance or equivalent mechanisms for uninsured or underinsured individuals and families pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight.

Notwithstanding any inconsistent provision of section one hundred twelve or one hundred seventy-four of the state finance law or any other

law, funds available for distribution pursuant to this subparagraph may be allocated and distributed without a competitive bid or request for proposal process.

(iii) Any unused funds from the allocations provided for in paragraph (b) and paragraph (e) of this subdivision and subparagraph (i) of this paragraph and any funds contingently allocated to regional pilot projects pursuant to subparagraph (i) of this paragraph if authorizing legislation is not enacted as required by such subparagraph shall be reallocated for use in accordance with the provisions of subparagraph (ii) of this paragraph.

(iv) Notwithstanding any inconsistent provision of this section, the commissioner shall enter into agreements with one or more persons, not-for-profit corporations, or other organizations, other than a state employee, official or agency, for the purposes of an independent evaluation of the implementation and effectiveness of primary care initiatives, including preferred primary care provider designations, applicable to general hospitals, diagnostic and treatment centers and participating practitioners and may allocate and distribute funds otherwise available for distribution in accordance with subparagraph (ii) of this paragraph for the costs of such evaluation. The evaluation shall assess factors including but not limited to:

(A) the overall effect of such primary care initiatives on access to and utilization of health care services;

(B) the extent to which such initiatives have fostered cooperative working relationships between various providers of health care services;

(C) the impact of such initiatives on the cost of health care services.

An initial evaluation pursuant to this subparagraph shall be submitted to the governor and the legislature on or before April first, nineteen hundred ninety-two and a further evaluation shall be submitted by April first, nineteen hundred ninety-three.

* 19-a. Health care services allowance statewide pool distribution. Funds accumulated in the statewide pool created by the allowance authorized in accordance with subparagraphs (ii) and (iii) of paragraph (a) of subdivision fourteen-b of this section, including income from invested funds, shall be distributed or retained in accordance with the

following:

(a) Funds shall be transferred to primary health care services regional pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with section twenty-eight hundred seven-bb of this article. Such funds shall be transferred to each regional pool so that the regional pool receives, for the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four fifty-one and five-tenths percent, January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five forty-nine and six-tenths percent, and January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six forty-nine and six-tenths percent of the total funds to be accumulated in the statewide pool from the allowance submitted by or on behalf of hospitals in that region. Such regions shall be those established for purposes of section two thousand nine hundred four-b of this chapter.

(b) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be available for primary care education and training. For the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, such percentage shall be twenty-two and one-tenth percent, and January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty and four-tenths percent, and January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six such percentage shall be twenty and four-tenths percent. Funds shall be available for distributions as follows:

(i) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for primary care undergraduate medical education in accordance with section nine hundred two of this chapter;

(ii) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care physician loan repayment program in accordance with section nine hundred three of this chapter;

(iii) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter;

(iv) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner education program in accordance with section nine hundred five of this chapter;

(v) the balance remaining annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated from year to year for distributions by the commissioner for health care development in accordance with section nine hundred six of this chapter; and

(vi) provided, however, that the commissioner in the absence of qualified recipients within a category may reallocate any funds remaining or unallocated within such a category for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter and the primary care practitioner education program in accordance with section nine hundred five of this chapter.

(c) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner into the miscellaneous special revenue fund - 339, health care planning account, which is established for services and expenses for health planning, for purposes of: (i) per capita support of health systems agencies, provided no health systems agency shall receive less than two hundred fifty thousand dollars annually from the per capita allocation, and provided further that a health systems agency receiving the minimum level of funding provided pursuant to a per capita formula shall also be entitled to receive matching support; (ii) matching support for other contributions received by health systems agencies from qualified sources as determined by the commissioner; (iii) five hundred thousand dollars for global budgeting demonstrations grants authorized pursuant to section twenty-eight hundred fourteen of this article; and (iv) five hundred thousand dollars for health networks grants authorized

pursuant to section twenty-eight hundred fourteen of this article. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four such percentage shall be eight and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six such percentage shall be eight and two-tenths percent.

(c-1) Notwithstanding any other provision of law to the contrary, any unspent funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision as of April first, nineteen hundred ninety-five and any additional funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the medical assistance program general fund - local assistance account.

(c-2) Notwithstanding any other provision of law to the contrary, funds accumulated for programs and services pursuant to subparagraphs (i) and (ii) of paragraph (c) of this subdivision for nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the general fund - local assistance account.

(d) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the emergency medical services training account established for purposes of section ninety-seven-q of the state finance law for services and expenses related to emergency medical services training and administration. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, such percentage shall be seventeen and six-tenths percent, for the rate period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty-one and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, such percentage shall be twenty-one and eight-tenths percent.

(f) Distributions from the pools created in accordance with this

subdivision and subdivision fourteen-b of this section, and the components of rates of payment or charges related to the allowances provided in accordance with subdivision fourteen-b of this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of this section, subject to the provisions of paragraph (e) of subdivision eighteen of this section, and shall not be included in gross receipts received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

(g) Notwithstanding any inconsistent provisions of law, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to sections twenty-eight hundred eight-c, twenty-eight hundred seven-a or this section of this article such funds as shall be necessary, not to exceed the amounts projected to be available pursuant to paragraph (d) of subdivision fourteen-b of this section, annually for distributions in accordance with paragraphs (a), (b), (c), (d) and (h) of this subdivision for a rate year and shall refund such moneys when pool funds become available pursuant to paragraphs (a), (b), (c), (d) and (h) of this subdivision for such rate year.

(h) Notwithstanding any inconsistent provision of this subdivision, prior to allocation of funds in accordance with paragraphs (a), (b), (c) and (d) of this subdivision from the allowance for the period July first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and from the allowance for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six, thirty-nine million five hundred thousand dollars from the nineteen hundred ninety-five pool and forty-four million five hundred thousand dollars from the nineteen hundred ninety-six pool respectively shall be reserved by the commissioner from the amount accumulated in the statewide pool, proportionally based on the total amount of funds projected to be accumulated in the pool for the year, for additional distributions in accordance with paragraph (b-1) of subdivision nineteen of this section to programs to provide health care coverage for uninsured or underinsured children, and the balance of funds accumulated in the statewide pool shall be

proportionally allocated in accordance with paragraphs (a), (b), (c) and (d) of this subdivision.

* NB Effective until December 31, 2029

* 19-a. Health care services allowance statewide pool distribution. Funds accumulated in the statewide pool created by the allowance authorized in accordance with subparagraphs (ii) and (iii) of paragraph (a) of subdivision fourteen-b of this section, including income from invested funds, shall be distributed or retained in accordance with the following:

(a) Funds shall be transferred to primary health care services regional pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with section twenty-eight hundred seven-bb of this article. Such funds shall be transferred to each regional pool so that the regional pool receives, for the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four fifty-one and five-tenths percent, January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five forty-nine and six-tenths percent, and January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six forty-nine and six tenths percent of the total funds to be accumulated in the statewide pool from the allowance submitted by or on behalf of hospitals in that region. Such regions shall be those established for purposes of section two thousand nine hundred four-b of this chapter.

(b) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be available for primary care education and training. For the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, such percentage shall be twenty-two and one-tenth percent, January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty and four-tenths percent, and January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six, such percentage shall be twenty and four-tenths percent. Funds shall be available for distributions as follows:

(i) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds

and may be accumulated for the following year for distribution by the commissioner for primary care undergraduate medical education in accordance with section nine hundred two of this chapter;

(ii) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care physician loan repayment program in accordance with section nine hundred three of this chapter;

(iii) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter;

(iv) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner education program in accordance with section nine hundred five of this chapter;

(v) the balance remaining annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated from year to year for distributions by the commissioner for health care development in accordance with section nine hundred six of this chapter; and

(vi) provided, however, that the commissioner in the absence of qualified recipients within a category may reallocate any funds remaining or unallocated within such a category for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter and the primary care practitioner education program in accordance with section nine hundred five of this chapter.

(c) A fixed percentage of the total funds accumulated in the statewide pool including income from invested funds, shall be deposited by the commissioner into the miscellaneous special revenue fund - 339, health care planning account, which is established for services and expenses for health planning, for purposes of: (i) per capita support of health systems agencies, provided no health systems agency shall receive less than two hundred fifty thousand dollars annually from the per capita

allocation, and provided further that a health systems agency receiving the minimum level of funding provided pursuant to a per capita formula shall also be entitled to receive matching support; (ii) matching support for other contributions received by health systems agencies from qualified sources as determined by the commissioner; (iii) five hundred thousand dollars for global budgeting demonstrations grants authorized pursuant to section twenty-eight hundred fourteen of this article; and (iv) five hundred thousand dollars for health networks grants authorized pursuant to section twenty-eight hundred fourteen of this article. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four such percentage shall be eight and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six such percentage shall be eight and two-tenths percent.

(c-1) Notwithstanding any other provision of law to the contrary, any unspent funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision as of April first, nineteen hundred ninety-five and any additional funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the medical assistance program general fund local assistance account.

(c-2) Notwithstanding any other provision of law to the contrary, funds accumulated for programs and services pursuant to subparagraphs (i) and (ii) of paragraph (c) of this subdivision for nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the general fund - local assistance account.

(d) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the emergency medical services training account established for purposes of section ninety-seven-q of the state finance law for services and expenses related to emergency medical services training and administration. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen

hundred ninety-four, such percentage shall be seventeen and six-tenths percent, for the rate period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty-one and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six, such percentage shall be twenty-one and eight-tenths percent.

(e) If on September thirtieth, nineteen hundred ninety-seven, any funds accumulated over the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six in the regional pools established pursuant to paragraph (a) of this subdivision are unused or uncommitted for the allocations provided for, such unused or uncommitted funds shall be reallocated for use in accordance with the provisions of subdivision seventeen of this section.

(f) Distributions from the pools created in accordance with this subdivision and subdivision fourteen-b of this section, and the components of rates of payment or charges related to the allowances provided in accordance with subdivision fourteen-b of this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of this section, subject to the provisions of paragraph (e) of subdivision eighteen of this section, and shall not be included in gross receipts received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

(g) Notwithstanding any inconsistent provisions of law, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to sections twenty-eight hundred eight-c, twenty-eight hundred seven-a or this section of this article such funds as shall be necessary, not to exceed the amounts projected to be available pursuant to paragraph (d) of subdivision fourteen-b of this section, annually for distributions in accordance with paragraphs (a), (b), (c), (d) and (h) of this subdivision for a rate year and shall refund such moneys when pool funds become available pursuant to paragraphs (a), (b), (c), (d) and (h) of this subdivision for such rate year.

(h) Notwithstanding any inconsistent provision of this subdivision,

prior to allocation of funds in accordance with paragraphs (a), (b), (c) and (d) of this subdivision from the allowance for the period July first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and from the allowance for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six, thirty-nine million five hundred thousand dollars from the nineteen hundred ninety-five pool and twenty-two million two hundred fifty thousand dollars from the nineteen hundred ninety-six pool respectively shall be reserved by the commissioner from the amount accumulated in the statewide pool, proportionally based on the total amount of funds projected to be accumulated in the pool for the year, for additional distributions in accordance with paragraph (b-1) of subdivision nineteen of this section to programs to provide health care coverage for uninsured or underinsured children, and the balance of funds accumulated in the statewide pool shall be proportionally allocated in accordance with paragraphs (a), (b), (c) and (d) of this subdivision.

* NB Effective December 31, 2029

* 19-b. Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision eighteen of this section for a period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand, including income from invested funds, shall be transferred by the commissioner and consolidated with funds accumulated from the allowance pursuant to subdivision two of section twenty-eight hundred seven-j of this article for such period and allocated in accordance with subdivision nine of section twenty-eight hundred seven-j of this article.

* NB Effective until December 31, 2029

* 19-b. Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision eighteen of this section for a period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, including income from invested funds, shall be transferred by the commissioner and consolidated with funds accumulated from the allowance pursuant to subdivision two of section twenty-eight hundred seven-j of this article for such period and allocated in accordance with

subdivision nine of section twenty-eight hundred seven-j of this article.

* NB Effective and repealed December 31, 2029

20. Payments to pools. (a) Payments by or on behalf of general hospitals to bad debt and charity care regional pools of funds due based on the allowance included in rates and charges in accordance with paragraph (c) of subdivision fourteen of this section and to regional pools created pursuant to paragraph (b) of subdivision fourteen-b and to a statewide pool created pursuant to paragraph (b) of subdivision fourteen-c of this section shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation; provided, however, that estimated payments of amounts due for patients discharged in a calendar month commencing on or after October first, nineteen hundred ninety-one must be made within sixty days of the end of each month unless payments of actual amounts due for such calendar months have been made within such sixty day time period. Upon receipt of notification from the commissioner, the comptroller, or a fiscal intermediary designated by the director of the budget, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or such article forty-three corporation or article forty-four organization to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment to the pools of funds due based on the allowances included in rates and charges in accordance with paragraph (c) of subdivision fourteen, paragraph (a) of subdivision fourteen-b and paragraph (a) of subdivision fourteen-c of this section. Upon withholding such amount, the comptroller, or a designated fiscal intermediary, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld for deposit into the applicable pool. Any general hospital in arrears resulting from failure to make a timely payment to a pool shall not be eligible for a

distribution from a bad debt and charity care regional pool in accordance with subdivision seventeen of this section until such arrearage is satisfied.

(b) (i) Payments by or on behalf of general hospitals to the bad debt and charity care and capital statewide pool of funds due from the assessments pursuant to subdivision eighteen of this section shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation; provided, however, that estimated payments of amounts due for patients discharged in a calendar month commencing on or after October first, nineteen hundred ninety-one must be made within sixty days of the end of each month unless payments of actual amounts due for such calendar months have been made within such sixty day time period. Upon receipt of notification from the commissioner, the comptroller, or a fiscal intermediary designated by the director of the budget, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or such article forty-three corporation or article forty-four organization to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment to the bad debt and charity care and capital statewide pool of funds due from the assessments. Upon withholding such amount, the comptroller, or a designated fiscal intermediary, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld for deposit into the applicable pool. Any general hospital in arrears resulting from failure to make a timely payment to the bad debt and charity care and capital statewide pool shall not be eligible for a distribution from the bad debt and charity care regional pools in accordance with subdivision seventeen of this section or the bad debt and charity care and capital statewide pool in accordance with subdivision nineteen of this section until such arrearage is satisfied.

(ii) For periods on and after January first, two thousand five, reports submitted by general hospitals to implement the assessment set forth in subdivision eighteen of this section shall be submitted

electronically in a form as may be required by the commissioner; provided, however, general hospitals are not prohibited from submitting reports electronically on a voluntary basis prior to such date, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall be verified with an electronic signature as prescribed by the commissioner.

(c) (i) Interest shall be due and payable to the commissioner by a general hospital or by a payor paying directly to a pool on the difference between the amount paid to a pool and the amount due to such pool by the hospital or payor from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

(ii) If a payment by a general hospital or by a payor paying directly to a pool is less than seventy percent of the amount due to such pool by the hospital or payor, a penalty shall be due and payable to the commissioner by the hospital or payor of five percent of the difference between the amount paid to the pool and the amount due to such pool when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

21. Maximum distributions. (a) No general hospital may receive in total from the distributions made in accordance with paragraph (b) of subdivision fourteen-c, paragraphs (a) and (b) of subdivision seventeen and paragraphs (c), (d) and (e) of subdivision nineteen of this section an amount which exceeds its need for financing losses related to bad debts and the costs of charity care as defined in paragraph (b) of subdivision fourteen of this section.

* (b)(i) No public general hospital may receive in total from disproportionate share payment distributions made in accordance with subdivision seventeen of this section and adjustments in accordance with subdivisions fourteen-a and fourteen-d of this section for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four or for annual rate periods beginning on January first on or after January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six, or made in accordance with section twenty-eight hundred seven-k of this article and adjustments in accordance with subdivision fourteen-f of this section for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section or subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such increase to such maximum or to the manner in which the limitation on disproportionate share payments is applied as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii) Reductions pursuant to this paragraph shall be made in the following sequence:

(A) for periods through December thirty-first, nineteen hundred ninety-six, adjustments in accordance with subdivision fourteen-d of

this section; adjustments in accordance with subdivision fourteen-a of this section; and distributions in accordance with subdivision seventeen of this section, and

(B) for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, adjustments in accordance with subdivision fourteen-f of this section; and distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) (A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six equal to one-half of such reduction.

(B) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of such reduction.

* NB Effective until December 31, 2029

* (b)(i) No public general hospital may receive in total from disproportionate share payment distributions made in accordance with subdivision seventeen of this section and adjustments in accordance with subdivisions fourteen-a and fourteen-d of this section for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four or for annual rate periods beginning on January first on or after January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six, or made in accordance with section twenty-eight hundred seven-k of this article and adjustments in accordance with subdivision fourteen-f of this section

for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section or subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such increase to such maximum or to the manner in which the limitation on disproportionate share payments is applied as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii) Reductions pursuant to this paragraph shall be made in the following sequence:

(A) for periods through December thirty-first, nineteen hundred ninety-six, adjustments in accordance with subdivision fourteen-d of this section; adjustments in accordance with subdivision fourteen-a of this section; and distributions in accordance with subdivision seventeen of this section, and

(B) for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, adjustments in accordance with subdivision fourteen-f of this section; and distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) (A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with subdivision seventeen of this section for a general hospital, such

general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six.

(B) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine equal to one-half of such reduction.

* NB Effective and expires December 31, 2029

* (b) (i) No public general hospital may receive in total from disproportionate share payment distributions made in accordance with subdivision seventeen of this section and adjustments in accordance with subdivisions fourteen-a and fourteen-d of this section for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four or for annual rate period beginning on January first on or after January first, nineteen hundred ninety-five an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such increase to such maximum or to the manner in which the limitation on disproportionate share payments is applied as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this

paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii) Reductions pursuant to this paragraph shall be made in the following sequence: adjustments in accordance with subdivision fourteen-d of this section; adjustments in accordance with subdivision fourteen-a of this section; and distributions in accordance with subdivision seventeen of this section.

(iii) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section equal to one-half of such reduction.

* NB Effective December 31, 2029

* (c)(i) No general hospital other than a public general hospital may receive in total from disproportionate share payment distributions made in accordance with paragraph (b) of subdivision fourteen-c, subdivision seventeen and paragraphs (c) and (d) of subdivision nineteen of this section and adjustments in accordance with subdivision fourteen-d of this section for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five or for the annual rate period beginning on January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, or made in accordance with section twenty-eight hundred seven-k of this article for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section or subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to

title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such modifications to the manner in which the limitation on disproportionate share payments is applied to such hospitals as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii)(A) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals other than financially distressed hospitals: adjustments in accordance with subdivision fourteen-d of this section; and distributions in accordance with subdivision seventeen of this section.

(B) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals designated as financially distressed hospitals: distributions in accordance with paragraph (b) of subdivision fourteen-c of this section; distributions in accordance with paragraphs (c) and (d) of subdivision nineteen of this section; and distributions in accordance with subdivision seventeen of this section.

(C) Reductions pursuant to this paragraph for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, shall be made from distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) (A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with paragraph (b) of subdivision fourteen-c of this section, paragraph (c) or (d) of subdivision nineteen of this section, subdivision fourteen-d of this section or subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to

federal financial participation from funds available pursuant to such subdivisions equal to one-half of such reduction for periods through December thirty-first, nineteen hundred ninety-six.

(B) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of such reduction.

* NB Effective until December 31, 2029

* (c)(i) No general hospital other than a public general hospital may receive in total from disproportionate share payment distributions made in accordance with paragraph (b) of subdivision fourteen-c, subdivision seventeen and paragraphs (c) and (d) of subdivision nineteen of this section and adjustments in accordance with subdivision fourteen-d of this section for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five or for the annual rate period beginning on January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, or made in accordance with section twenty-eight hundred seven-k of this article for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section or subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such modifications

to the manner in which the limitation on disproportionate share payments is applied to such hospitals as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii)(A) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals other than financially distressed hospitals: adjustments in accordance with subdivision fourteen-d of this section; and distributions in accordance with subdivision seventeen of this section.

(B) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals designated as financially distressed hospitals: distributions in accordance with paragraph (b) of subdivision fourteen-c of this section; distributions in accordance with paragraphs (c) and (d) of subdivision nineteen of this section; and distributions in accordance with subdivision seventeen of this section.

(C) Reductions pursuant to this paragraph for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, shall be made from distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) (A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with paragraph (b) of subdivision fourteen-c of this section, paragraph (c) or (d) of subdivision nineteen of this section, subdivision fourteen-d of this section or subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to such subdivisions equal to one-half of such reduction for periods through December thirty-first, nineteen hundred ninety-six.

(B) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine equal to one-half of such reduction.

* NB Effective and expires December 31, 2029

* (c) (i) No general hospital other than a public general hospital may receive in total from disproportionate share payment distributions made in accordance with paragraph (b) of subdivision fourteen-c, subdivision seventeen and paragraphs (c) and (d) of subdivision nineteen of this section and adjustments in accordance with subdivision fourteen-d of this section for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five or for the annual rate period beginning on January first, nineteen hundred ninety-six an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to subdivision twenty-six of this section, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such modifications to the manner in which the limitation on disproportionate share payments is applied to such hospitals as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii)(A) Reductions pursuant to this paragraph shall be made in the

following sequence for general hospitals other than financially distressed hospitals: adjustments in accordance with subdivision fourteen-d of this section; and distributions in accordance with subdivision seventeen of this section.

(B) Reductions pursuant to this paragraph shall be made in the following sequence for general hospitals designated as financially distressed hospitals: distributions in accordance with paragraph (b) of subdivision fourteen-c of this section; distributions in accordance with paragraphs (c) and (d) of subdivision nineteen of this section; and distributions in accordance with subdivision seventeen of this section.

(iii) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with paragraph (b) of subdivision fourteen-c of this section, paragraph (c) or (d) of subdivision nineteen of this section, subdivision fourteen-d of this section or subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to such subdivisions equal to one-half of such reduction.

* NB Effective December 31, 2029

* (d)(i) Commencing April first, nineteen hundred ninety-four, no general hospital may be eligible to receive disproportionate share payments determined in accordance with subdivision twenty-six of this section through December thirty-first, nineteen hundred ninety-six or in accordance with section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand unless the hospital has an inpatient utilization rate for patients eligible for payments pursuant to title eleven of article five of the social services law eligible for federal financial participation pursuant to title nineteen of the federal social security act of not less than one percent.

(ii) In the event a general hospital is disqualified pursuant to subparagraph (i) of this paragraph from receiving disproportionate share payments for a period, such general hospital shall receive distributions not as disproportionate share payments and not subject to federal financial participation from funds available pursuant to subdivision

seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of the distributions for which such general hospital would have been qualified pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand without consideration of subparagraph (i) of this paragraph.

* NB Effective until December 31, 2029

* (d)(i) Commencing April first, nineteen hundred ninety-four, no general hospital may be eligible to receive disproportionate share payments determined in accordance with subdivision twenty-six of this section through December thirty-first, nineteen hundred ninety-six or in accordance with section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine unless the hospital has an inpatient utilization rate for patients eligible for payments pursuant to title eleven of article five of the social services law eligible for federal financial participation pursuant to title nineteen of the federal social security act of not less than one percent.

(ii) In the event a general hospital is disqualified pursuant to subparagraph (i) of this paragraph from receiving disproportionate share payments for a period, such general hospital shall receive distributions not as disproportionate share payments and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine equal to one-half of the distributions for which such general hospital would have been qualified pursuant to

subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine without consideration of subparagraph (i) of this paragraph.

* NB Effective and expires December 31, 2029

* (d)(i) Commencing April first, nineteen hundred ninety-four, no general hospital may be eligible to receive disproportionate share payments determined in accordance with subdivision twenty-six of this section unless the hospital has an inpatient utilization rate for patients eligible for payments pursuant to title eleven of article five of the social services law eligible for federal financial participation pursuant to title nineteen of the federal social security act of not less than one percent.

(ii) In the event a general hospital is disqualified pursuant to subparagraph (i) of this paragraph from receiving disproportionate share payments for a period, such general hospital shall receive distributions not as disproportionate share payments and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section equal to one-half of the distributions for which such general hospital would have been qualified pursuant to subdivision seventeen of this section without consideration of subparagraph (i) of this paragraph.

* NB Effective December 31, 2029

* (e) For purposes of calculations pursuant to paragraphs (b) and (c) of this subdivision of maximum disproportionate share payment distributions for a year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than disproportionate share payments, and payments by uninsured patients shall be determined initially based on base year data and statistics for the base year two years immediately preceding the year projected to the year by the trend factor determined in accordance with subdivision ten of this section and shall be subsequently revised to reflect actual period data and statistics. For purposes of calculations pursuant to paragraph (d) of this subdivision of eligibility to receive disproportionate share payments for a year or part thereof, the hospital

inpatient utilization rate shall be determined based on base year statistics in accordance with a methodology established by the commissioner, and costs incurred of furnishing hospital services shall be determined in accordance with a methodology established by the commissioner consistent with requirements of the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act in disproportionate share payments.

* NB Effective until December 31, 2029

* (e) For purposes of calculations pursuant to paragraphs (b) and (c) of this subdivision of maximum disproportionate share payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than disproportionate share payments, and payments by uninsured patients shall be determined initially based on base year data and statistics for the base year two years immediately preceding the rate year projected to the rate year by the trend factor determined in accordance with subdivision ten of this section and shall be subsequently revised to reflect actual rate period data and statistics. For purposes of calculations pursuant to paragraph (d) of this subdivision of eligibility to receive disproportionate share payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on base year statistics in accordance with a methodology established by the commissioner, and costs incurred of furnishing hospital services shall be determined in accordance with a methodology established by the commissioner consistent with requirements of the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act in disproportionate share payments.

* NB Effective December 31, 2029

(e-1) For periods on and after January first, two thousand eleven, for purposes of calculations pursuant to paragraphs (b) and (c) of this subdivision of maximum disproportionate share payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than disproportionate share payments, and payments by uninsured patients shall for the two thousand eleven calendar year, shall be determined initially based on

each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, which is required to be submitted to the department by March thirty-first, two thousand eleven, and shall be subsequently revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool, which is required to be submitted to the department by October first, two thousand eleven.

For calendar years on and after two thousand twelve, such initial determinations shall reflect submission of data as required by the commissioner on a specified date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates prescribed in this paragraph, provided, however, that such payments shall be made upon submission of such required data. For purposes of calculations pursuant to paragraph (d) of this subdivision of eligibility to receive disproportionate share payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics in accordance with the methodology established by the commissioner, and costs incurred of furnishing hospital services shall be determined in accordance with a methodology established by the commissioner consistent with requirements of the secretary of the department of health and human services for purposes of federal financial participation pursuant to the title XIX of the federal social security act in disproportionate share payments.

(f) The commissioner may recover any amounts paid in excess of maximum permissible distributions and adjustments determined pursuant to this subdivision by retroactive adjustment and recoupment from payments made for beneficiaries eligible for payments pursuant to title eleven of article five of the social services law.

(g) Notwithstanding any inconsistent provision of this subdivision, the provision of subparagraph (iii) of paragraph (b), subparagraph (iii) of paragraph (c) or subparagraph (ii) of paragraph (d) of this subdivision shall be of no force and effect and shall be deemed to have been null and void as of January first, nineteen hundred ninety-four in the event the secretary of the department of health and human services

determines that distributions based on such provisions would render a health care related tax on general hospitals an impermissible health care related tax for purposes of the federal medicaid voluntary contribution and provider specific tax amendments of nineteen hundred ninety-one for purposes of such health care related tax receipts reducing the amount deemed expended by the state as medical assistance for purposes of federal financial participation.

22. Undistributed funds. Any funds, including income from invested funds, remaining in the bad debt and charity care and capital statewide pool after distributions in accordance with paragraphs (a), (b), (b-1), (c), (d), (e) and (f) of subdivision nineteen of this section shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, excluding major public general hospitals, on the basis of hospital specific assessments submitted to the pool.

23. Reimbursement rates. The assessments pursuant to subdivision eighteen of this section shall not be an allowable cost in the determination of general hospital inpatient reimbursement rates in accordance with this section and section twenty-eight hundred seven of this article.

24. Federal financial participation. The council may adopt rules and regulations, subject to the approval of the commissioner, to adjust rates of payment by governmental agencies for general hospital inpatient services determined in accordance with this section as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act in the event the state cannot provide assurances satisfactory to the secretary of health and human services related to a comparison of rates of payment in the aggregate to maximum aggregate payments determined in accordance with federal law and regulation which are substantially the same as such assurances as in effect on October twenty-sixth, nineteen hundred eighty-seven for securing such federal financial participation. Notwithstanding any other law, the state reserves the right to recoup any payments by governmental agencies for general hospital inpatient services authorized by this section for which federal financial

participation has been denied in connection with that determination by the department of health and human services.

25. Medical education expenses. (a) Notwithstanding any inconsistent provision of this section, to encourage the training of more primary care physicians, for annual rate periods beginning on or after January first, nineteen hundred ninety-two, indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, of a general hospital included in the determination of the operating cost component of general hospital rates of payment for a rate period in accordance with subdivisions six and seven of this section or in accordance with paragraph (e), (g) or (i) of subdivision four of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge shall be adjusted to reflect the following modifications:

(i) the calculation of interns and residents to bed ratios for purposes of determining indirect reimbursement shall include residents in non-hospital ambulatory settings. The sum in total for all general hospitals of the indirect medical education expenses shall equal the sum in total for each general hospital determined as if the provisions of this section were applied without consideration of residents in non-hospital ambulatory settings; and

(ii) for annual rate periods beginning on or after January first, nineteen hundred ninety-two, residencies shall be weighted to provide higher weights for primary care and emergency medicine physicians. Primary care residents specialties shall include family medicine, general pediatrics, primary care internal medicine and primary care obstetrics and gynecology. In determining whether a residency is in primary care, the commissioner shall consult with the New York state council on graduate medical education and the state hospital review and planning council. Reimbursable indirect expenses of medical education of a general hospital for a rate period shall be weighted based on projected medical education statistics for such general hospital for such rate period, and subsequently reconciled through appropriate audit procedures to actual statistics by a prospective adjustment to rates of payment. The weighting factors shall be determined based on nineteen hundred ninety data and statistics and shall include residents

identified in subparagraph (i) of this paragraph not previously included in such calculations such that the sum in total for all general hospitals of the results of the weighting factors multiplied by the indirect medical education expenses for each general hospital shall equal, approximately, the sum in total for all general hospitals of the indirect medical education expenses for each general hospital determined as if the provisions of this section were applied without consideration of the weighting factors or residents in non-hospital ambulatory settings determined pursuant to this subdivision. Residency positions in any specialty shall be weighted to equal no less than nine-tenths of what such position would have equaled if reimbursement were to have been calculated without regard to the weighting factors. If a general hospital is reimbursed by this provision in excess of the amount such hospital would have been reimbursed without regard to the weighting factors, such general hospital shall apply such additional funds to encourage the training of primary care physicians. The provisions of this subparagraph shall not apply to those four specialty eye and ear, special surgery and orthopedic and joint disease hospitals, specified by the commissioner, whose primary mission is to engage in research, training, and clinical care in the above-named areas.

(b) Hospitals shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality and health system needs for medical education provided.

(c) For purposes of determining how such weighting factors have resulted in the increased training of physicians in primary care specialties, the council on graduate medical education shall prepare a report on or before March thirty-first, nineteen hundred ninety-five. Such report shall include, but shall not be limited to: an evaluation of the effectiveness such weighting factors have had on the number of residents matched in primary care specialties; the degree to which such weighting factors have impacted general hospitals to redirect their residency programs toward training primary care physicians; and the impact such weighting factors have had on graduate medical education within general hospitals. Such report shall also include recommendations to the governor and the legislature on the continuation, expiration or modification of such weighting factors.

(d) Notwithstanding any inconsistent provision of this section and

subject to the availability of federal financial participation:

(i) For periods on and after April first, two thousand four, the commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section, including discrete rates of payment calculated pursuant to paragraph a-three of subdivision one of this section, for non-public general hospitals, and for periods on and after April first, two thousand seven, for public and non-public general hospitals, in accordance with subparagraph (ii) of this paragraph, for purposes of reimbursing graduate medical education costs based on the following methodology:

(ii) Rate adjustments for each general hospital shall be based on the difference between the graduate medical education component, direct and indirect, of the two thousand three medical assistance inpatient rates of payment, including exempt unit per diem rates, and an estimate of what the graduate medical education component, direct and indirect, of such medical assistance inpatient rates of payment, including exempt unit per diem rates would be, stated at two thousand three levels and calculated as follows:

(A) Each general hospital's total direct medical education costs as reported in the two thousand one institutional cost report submitted as of December thirty-first, two thousand three, and

(B) An estimate of the total indirect medical education costs for two thousand one calculated in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs pursuant to subparagraph (ii) of paragraph (c) of subdivision seven of this section. The indirect medical education costs shall equal the product of two thousand one hospital specific inpatient operating costs, including exempt unit costs, and the indirect teaching cost percentage determined by the following formula:

$$1 - (1 / (1 + 1.89((1 + r)^{.405} - 1)))$$

where r equals the ratio of residents and fellows to beds for two thousand one adjusted to reflect the projected two thousand three resident counts.

(C) Each hospital's rate adjustment shall be limited to seventy-five percent of the graduate medical education component included in its two thousand three medical assistance inpatient rates of payment, including exempt unit rates. For periods on and after April first, two thousand

seven, the seventy-five percent limit shall not apply to rate decreases calculated pursuant to this paragraph.

(D) For the period April first, two thousand four through March thirty-first, two thousand seven, no hospital shall receive a rate adjustment pursuant to this paragraph if such rate adjustment would be a negative amount. For periods on and after April first, two thousand seven, no public general hospital shall receive a rate increase calculated pursuant to this paragraph.

(iii) If the aggregate amount of rate adjustments calculated pursuant to this paragraph exceeds the upper payment limit calculated pursuant to federal regulations, such rate adjustments shall be reduced proportionally by the amount in excess of the federal upper payment limit. Such reduction, if applicable, shall be calculated on an annual basis.

(iv) Such rate adjustment shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, but including inpatient rates of payment established in accordance with paragraph a-three of subdivision one of this section. Such rate add-on shall be based on medical assistance data reported in each hospital's annual cost report submitted for the period two years prior to the rate year and filed with the department by November first of the year prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(e) From amounts available pursuant to paragraph (oo) of subdivision one of section twenty-eight hundred seven-v of this article, allocations shall be made to non-public general hospitals receiving a rate adjustment pursuant to paragraph (d) of this subdivision when the rate adjustment pursuant to paragraph (d) of this subdivision results in the general hospital exceeding its applicable disproportionate share payment limit in the year in which the adjustment is made and the amount of the associated reduction in the hospital's disproportionate share payments would result in the hospital receiving less than its total distribution amount in that year. A hospital's "total distribution amount" shall be the amount that the hospital would have received pursuant to paragraphs (c) and (d) of subdivision three of section twenty-eight hundred seven-m of this article prior to the effective date of this paragraph. A

hospital's eligible loss for purposes of this paragraph shall be the amount of the loss in such total distribution amount. Each eligible hospital's allocation of available funds pursuant to this paragraph within a year shall be determined based on its proportionate share of the aggregate eligible losses for all such hospitals, limited by the amount of the rate adjustment pursuant to paragraph (d) of this subdivision.

26. Disproportionate share payments. Distributions to general hospitals from bad debt and charity care regional pools pursuant to subdivision seventeen of this section, distributions to general hospitals from the bad debt and charity care and capital statewide pool pursuant to paragraphs (c) and (d) of subdivision nineteen of this section, distributions to general hospitals from the bad debt and charity care for financially distressed hospitals statewide pool pursuant to subdivision fourteen-c of this section and the adjustment provided in accordance with subdivision fourteen-a of this section and the adjustment provided in accordance with subdivision fourteen-d of this section shall be considered disproportionate share payments for inpatient hospital services to general hospitals serving a disproportionate number of low income patients with special needs for purposes of providing assurances to the secretary of health and human services as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act.

27. Reports. (a) The commissioner of health shall submit a report to the legislature and the council on health care financing on or before February first, nineteen hundred eighty-eight detailing the objective, impact, design and computation for an inpatient pricing component. In terms of the design and computation for a pricing system such report shall include but not be limited to: a description and methodology for developing peer groups, identification of costs included in the calculation of a group average and any adjustments made to such costs, the methodology developed to reflect outliers, any teaching or disproportionate share adjustments made, the calculation of wage and power equalization factors, and identification of any adjustments made

to the service intensity weights or diagnosis-related group categories. The commissioner shall explore methodologies for the inclusion of severity of illness considerations in determining group average costs and rates and shall include all details of his analysis in the report required under this subparagraph. If it is determined that a severity of illness adjustment cannot be developed for incorporation in the computations, the report filed shall include the specific reasons for this conclusion. With regard to a fiscal impact analysis such report shall include but not be limited to the impact on major types of general hospitals including rural, urban, teaching, non-teaching, plus a regional analysis; and should indicate any characteristics which can be observed regarding general hospitals which would be significantly impacted by the introduction of a pricing component. The commissioner shall expeditiously make available for inspection by interested parties pertinent data used in the development of the inpatient pricing component consistent with appropriate department procedures for the release and protection of confidential data.

(b) The commissioner shall submit a report to the governor and the legislature on or before February first, nineteen hundred ninety-five regarding the objective, impact, design and implementation of the case based payment system for inpatient hospital services based on diagnosis-related groups created pursuant to this section including, in particular, an analysis of the group price component of case based rates of payment and the appropriateness and effectiveness of the provisions relating to financing of uncompensated care. The reports shall include but not be limited to a fiscal impact analysis of the impact of the case based payment system on major types of general hospitals including rural, urban, teaching and non-teaching, plus a regional analysis. Such reports shall evaluate the impact of the case based payment system on general hospital inpatient medical and clinical care and the quality of hospital services. The reports shall also include recommendations for continuation or modification of the case based payment system for inpatient hospital services provided on or after January first, nineteen hundred ninety-six.

** (c) The commissioner shall report to the governor and the legislature on or before December first, nineteen hundred eighty-eight with a plan relating to the structure and financing of graduate medical

education. Such plan shall include an evaluation of and recommendations for graduate medical education with respect to health services delivery and educational goals including but not limited to the following: appropriate supply and distribution of primary care providers by geographic area; adequate supply and distribution of medical specialists according to projected population needs; educational opportunities representative of current and future practice settings; the impact of such plan on health care delivery in currently underserved and rural areas; and reimbursement changes to effectuate the recommendations included in the plan. Such plan shall be developed with substantial participation by the department of education, the medical schools, residency training programs, health systems agencies, health care institutions, and physicians.

** NB Inadvertently omitted from 731/93 amendment

* 28. Notwithstanding any inconsistent provision of this section:

(a) the commissioner may adjust, on a per unit of service basis, general hospital inpatient services rates of payment established pursuant to this section as in effect on and before December thirty-first, nineteen hundred ninety-six prospectively as an additional factor to be paid, including the impact of payment differentials as were in effect pursuant to this section, in addition to, or as a reduction to, any hospital charges or negotiated rate (the adjustment may not be negotiated by the payor); including, but not limited to, capital related inpatient expenses reconciliation adjustments pursuant to subdivision eight of this section, rate adjustments for corrections, appeals and volume changes pursuant to subdivision nine of this section, rate adjustments to reflect trend factor adjustments pursuant to subdivision ten of this section, maximum case mix change adjustments pursuant to paragraph (f) of subdivision eleven of this section, and adjustments based on audits;

(b) the allowances percentages established pursuant to this article in effect for a rate period shall be applied to hospital charges or negotiated rates plus the prospectively adjusted payment of rates of payment of a general hospital in accordance with paragraph (a) of this subdivision;

(c) no recalculation of the basis for distribution of funds from regional or statewide pools established pursuant to this section shall

be made based on the impact of a prospective adjustment to rates of payment authorized pursuant to this subdivision; and

(d) prospective rate adjustments authorized pursuant to this subdivision for a general hospital based on appeals approved after January first, nineteen hundred ninety-eight shall be included in rates of payment as a one hundred percent facility specific adjustment and shall not affect the calculation of the group category average inpatient reimbursable operating cost per discharge for such retrospective period for any other general hospital.

* NB Expires December 31, 2029

* 29. Coinsurance and deductibles. (a) If a general hospital and a third-party payor agree to a negotiated payment methodology for a period on or after January first, nineteen hundred ninety-seven that is based on a discount from hospital charges, such discount shall apply to the calculation of the charge basis for deductible and coinsurance amounts for such period owed for any patient covered by such third-party payor as the primary payor.

(b) If a general hospital and a third-party payor agree to a negotiated payment methodology for a period on or after January first, nineteen hundred ninety-seven that is not based on a discount from hospital charges, excluding capitation arrangements, the maximum amount to be charged for deductible and coinsurance amounts for such period for any patient covered by such third-party payor as the primary payor shall not exceed the amount calculated by applying the deductible and coinsurance amounts to the amount due on the basis of such negotiated payment arrangement.

* NB Expires December 31, 2029

30. General hospital recruitment and retention of health care workers. Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation:

(a) (i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for non-public general hospitals in accordance with subparagraph (ii) of this paragraph for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) ninety-three million two hundred thousand dollars on an annualized

basis for the period April first, two thousand two through December thirty-first, two thousand two; one hundred eighty-seven million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; two hundred sixty-two million one hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; one hundred thirty-one million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and two hundred forty-three million five hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, two hundred forty-three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine; one hundred sixty-three million one hundred forty-five thousand dollars for the period April first, two thousand nine through November thirtieth, two thousand nine.

(ii) Such increases shall be allocated proportionally based on each non-public general hospital's reported total gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one to the total of such reported costs for all non-public general hospitals, provided, however, that for periods on and after July first, two thousand seven, fifty percent of such increases shall be allocated proportionally, based on each non-public hospital's reported total gross salary and fringe benefit costs, as reported on exhibit 11 of the nineteen hundred ninety-nine institutional cost report as submitted to the department prior to November first, two thousand one, to the total of such reported costs for all non-public general hospitals, and fifty percent of such increases shall be allocated proportionally, based on each such hospital's total reported medicaid inpatient discharges, as reported in the two thousand four institutional cost report as submitted to the department prior to November first, two thousand six, to the total of such reported medicaid inpatient discharges for all non-public general hospitals, as weighted proportionally to reflect the relative medicaid case mix of each such hospital. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for non-public general

hospitals based on medical assistance utilization data in each hospital's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based on data reported in each hospital's cost report for the respective rate year. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for non-public general hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. For rate adjustments effective May first, two thousand five and thereafter such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(b) (i) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent provision of law, the commissioner shall make grants to public general hospitals without a competitive bid or request for proposal process for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) eighteen million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; twenty-six million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, forty-nine million dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and forty-nine million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such grants shall be allocated proportionally based on each public general hospital's reported total gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report

submitted as of November first, two thousand one to the total of such reported costs for all public general hospitals.

(c) From amounts available pursuant to paragraph (gg) of subdivision one of section twenty-eight hundred seven-v of this article, allocations shall be made to non-public general hospitals whose allocated labor adjustments pursuant to paragraphs (a) and (e) of this subdivision and adjustment pursuant to subdivision thirty-two of this section results in the general hospital exceeding its applicable disproportionate share payment limit. Each such hospital's allocation of available funds pursuant to this paragraph within a year shall be determined based on its proportionate share of the aggregate reduction of federal disproportionate share funding for all such hospitals for the year resulting from the allocated labor adjustments pursuant to paragraphs (a) and (e) of this subdivision and from the adjustment pursuant to subdivision thirty-two of this section.

(d) General hospitals which have their rates adjusted or receive grants pursuant to paragraphs (a) and (b) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such general hospital shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each general hospital to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

(e)(i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for general hospitals in accordance with subparagraph (ii) of this paragraph and

shall establish discrete rates of payment for such hospitals in accordance with subparagraph (iii) of this paragraph, for purposes of additional support of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) one hundred twenty-one million dollars for the period May first, two thousand five through December thirty-first, two thousand five and one hundred twenty-one million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(ii) Such increases shall be allocated proportionally based on each general hospital's reported gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one to the total of such reported costs for all general hospitals. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for general hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(iii) The commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for general hospitals for payments under the medical assistance program pursuant to titles eleven and eleven-D of article five of the social services law for persons eligible for medical assistance and family health plus who are enrolled in health maintenance organizations based on the calculation set forth in subparagraph (ii) of this paragraph for such general hospitals. If discrete rates of payment under this subparagraph are not established, the commissioner shall adjust the calculation established pursuant to subparagraph (ii) of this paragraph to account for medical assistance utilization described under this subparagraph for such non-public general hospital.

(iv) Payment of the non-federal share of the medical assistance payments made pursuant to this paragraph shall be the responsibility of the state and shall not include a local share. Payments made pursuant to this paragraph or pursuant to paragraph (a) of this subdivision may be

added to rates of payment or made as aggregate payments to eligible general hospitals.

(f) In the event that a hospital entitled to an adjustment pursuant to paragraph (a) or (e) of this subdivision closes or otherwise experiences a change in status that eliminates its ability to continue to receive such adjustments, the commissioner shall allocate the amount determined under subparagraph (ii) of paragraph (a) and subparagraph (ii) of paragraph (e) of this subdivision for such hospital to hospitals in the immediate region of the closing hospital based upon the remaining hospitals' reported gross salary and fringe benefit costs as reported on exhibit eleven of the two thousand four institutional cost report submitted as of November first, two thousand five to the total of such reported costs for all general hospitals in the region, provided, however, that for periods on and after July first, two thousand seven, such allocations shall be based on such remaining hospitals' reported medicaid inpatient discharges, as reported in the two thousand four institutional cost report submitted to the department prior to November first, two thousand six, to the total of such reported medicaid inpatient discharges for all such remaining hospitals. The commissioner shall define the immediate region as the county or counties within which workers displaced from the closing hospital are likely to seek re-employment.

31. Supplemental general hospital recruitment and retention adjustment. (a) Notwithstanding any law, rule or regulation to the contrary, the commissioner shall, within amounts appropriated, and contingent on the availability of federal financial participation, make Medicaid rate adjustments for non-public general hospitals to address extraordinary costs associated with recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility at such general hospitals. Eligible hospitals shall be selected by the commissioner pursuant to a competitive process. Requests for proposals for eligible projects shall be issued by the commissioner.

(b) Such eligible projects may include:

(i) an increase in non-supervisory staff, either facility wide or targeted at a particular area of care or shift;

(ii) increased training and education of non-supervisory staff, including allowing non-supervisory staff to increase their level of licensure relevant to general hospital care;

(iii) efforts to decrease staff turn-over; and

(iv) other efforts related to the recruitment and retention of non-supervisory staff or any worker with direct patient care responsibility that will affect the quality of care at such facility.

(c) The commissioner shall consider, in selecting eligible projects, the likelihood that such project will provide needed resources to meet legal commitments for increased labor costs, the financial need of the facility, the existence of a shortage of qualified hospital workers in the geographic area in which the facility is located, the existence of high employee turn-over at the facility and such other matters as the commissioner deems appropriate.

(d) In implementing rate adjustments authorized under this subdivision, the commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for non-public general hospitals for payments under the medical assistance program pursuant to titles eleven and eleven-D of article five of the social services law for persons eligible for medical assistance and family health plus who are enrolled in health maintenance organizations.

(e) Adjustments to Medicaid rates of payment made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

(f) Adjustments to Medicaid rates of payment made pursuant to this section shall not, in aggregate, exceed fifteen million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two and, on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand six, and shall not, in aggregate, exceed seven million five hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

32. Rural hospital supplemental rate adjustment. Notwithstanding any inconsistent provision of this section:

(a) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for rural hospitals as

defined in paragraph (c) of subdivision one of section twenty-eight hundred seven-w of this article in accordance with paragraph (b) of this subdivision for purposes of supporting critically needed health care services in rural areas in the following aggregate amounts for the following periods:

seven million dollars for the period May first, two thousand five through December thirty-first, two thousand five, seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six, seven million dollars for the period April first, two thousand seven through December thirty-first, two thousand seven, seven million dollars for calendar year two thousand eight, and six million four hundred seventeen thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(b) Such increases shall be allocated proportionately based on each such rural hospital's total reported medicaid inpatient discharges as reported in the two thousand two institutional cost report to the total of such discharges for all rural hospitals. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for rural hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(c) Payment of the non-federal share of the medical assistance payments made pursuant to this subdivision shall be the responsibility of the state and shall not include a local share. Payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals.

33. Notwithstanding any provision of law which is inconsistent with or contrary to the structure established by this subdivision and subdivision two-a of section twenty-eight hundred seven of this article in order to transition from nineteen hundred eighty-one base year costs

to two thousand five base year costs by no later than December thirty-first, two thousand twelve, and subject to the availability of federal financial participation, medicaid per diem and per discharge rates of payment for general hospital inpatient services for discharges and days occurring on and after December first, two thousand eight, shall be computed in accordance with the following:

(a)(i) for the period December first, two thousand eight through March thirty-first, two thousand nine, such rates shall be subject to a uniform transition adjustment which shall be based on each general hospital's proportional share of projected medicaid reimbursable inpatient operating costs and result in an aggregate reduction in such rates equal to fifty-one million five hundred thousand dollars, as determined by the commissioner, provided, however, that such transition adjustment shall not apply to rates computed pursuant to paragraph (1) of subdivision four of this section; and

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, such rates shall be revised pursuant to a chapter of the laws of two thousand nine and as reflecting the findings and recommendations of the commissioner as issued pursuant to the provisions of paragraph (b) of this subdivision, provided, however, that such revisions shall reflect an aggregate reduction in such rates of no less than one hundred fifty-four million five hundred thousand dollars, provided further, however, that, notwithstanding any contrary provision of law, as determined by the commissioner, to the extent that a chapter of the laws of two thousand nine is not enacted resulting in such an aggregate annual reduction of no less than one hundred fifty-four million five hundred thousand dollars in such rates, the commissioner shall implement a uniform reduction of such rates in accordance with the methodology described in subparagraph (i) of this paragraph to the extent necessary, as determined by the commissioner, to achieve such an aggregate reduction in such rates for the state fiscal year beginning April first, two thousand nine and each state fiscal year thereafter; and

(iii) for the periods April first, two thousand ten through March thirty-first, two thousand twelve, rates shall reflect prior year rate reductions and such additional reductions as are required to establish rates based on two thousand five reported allowable Medicaid costs

pursuant to a chapter of the laws of two thousand ten.

(b) In consultation with the chairs of the senate and assembly health committees, the commissioner shall, by no later than July first, two thousand eight, establish a technical advisory committee for the purposes of examining data and evaluating rate-setting methodological issues, including the impact on hospitals of different methodologies in preparation for the phased transition to the utilization of reported allowable two thousand five operating costs for the purpose of setting inpatient rates of payment for periods on and after April first, two thousand nine, which phased transition shall be authorized in accordance with a chapter of the laws of two thousand nine. The technical advisory committee shall consist of three representatives of hospital associations, two representatives of the health care industry and three representatives of community providers and consumers as determined by the commissioner. By no later than August first, two thousand eight, the commissioner shall make available to the technical advisory committee updated data and documentation relevant to the projected phased transition to utilization of reported allowable two thousand five operating costs for rate-setting purposes. The issues to be examined by the technical advisory committee shall include, but not be limited to, hospital re-basing, workforce recruitment and retention funding, graduate medical education funding, peer group pricing, wage equalization factors, case mix and such other related elements of the general hospital inpatient reimbursement system as deemed appropriate by the commissioner. The technical advisory committee shall also examine the scope and volume of hospital out-patient services. By no later than November first, two thousand eight the commissioner shall issue a report setting forth findings and recommendations, including divergent views of members of the technical advisory committee members concerning the matters examined by the technical advisory committee and the projected phased transition to utilization of two thousand five base year reported allowable operating costs for inpatient rates of payments on and after April first, two thousand nine.

(c) Paragraph (a) of this subdivision shall be effective the later of: (i) December first, two thousand eight; (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX

of the federal social security act for the rate methodology established pursuant to subdivision two-a of section twenty-eight hundred seven of this article; or (iii) after the commissioner determines that the department of health has the capability, for payments made pursuant to subdivision two-a of section twenty-eight hundred seven of this article, to electronically receive and process claims and transmit payments with remittance statements. Prior to the commissioner making such a determination, the department shall provide training sessions on the rate methodology and billing requirements for services pursuant to subdivision two-a of section twenty-eight hundred seven of this article and opportunity for hospitals to perform end-to-end testing on claims submission, processing and payment.

34. Enhanced safety net hospital program. (a) For the purposes of this subdivision, "enhanced safety net hospital" shall mean a hospital which:

(i) in any of the previous three calendar years, has met the following criteria:

(A) not less than fifty percent of the patients it treats receive medicaid or are medically uninsured;

(B) not less than forty percent of its inpatient discharges are covered by medicaid;

(C) twenty-five percent or less of its discharged patients are commercially insured;

(D) not less than three percent of the patients it provides services to are attributed to the care of uninsured patients; and

(E) provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care;

(ii) is a public hospital operated by a county, municipality, public benefit corporation or the state university of New York;

(iii) is an acute children's hospital licensed by the department primarily for the provision of pediatric and neonatal services for which a discrete institutional cost report was filed for the past three calendar years, and which has medicaid discharges in excess of fifty percent of its total discharges;

(iv) is federally designated as a critical access hospital; or

(v) is federally designated as a sole community hospital.

(b) Within amounts appropriated, the commissioner shall adjust medical assistance rates to enhanced safety net hospitals for the purposes of supporting critically needed health care services and to ensure the continued maintenance and operation of such hospitals.

(c) Payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals.

35. Notwithstanding any inconsistent provision of this section, or any other contrary provision of law and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospital inpatient services with regard to discharges occurring on and after December first, two thousand nine shall be in accordance with the following:

(a) For periods on and after December first, two thousand nine the operating cost component of such rates of payments shall reflect the use of two thousand five operating costs as reported by each facility to the department prior to July first, two thousand nine and as otherwise computed in accordance with the provisions of this subdivision;

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the computation of general hospital inpatient rates and such regulations shall include, but not be limited to, the following:

(i) The computation of a case-mix neutral statewide base price, applicable to each rate period, but excluding adjustments for graduate medical education costs, high cost outlier costs, costs related to patient transfers, and other non-comparable costs as determined by the commissioner, such statewide base prices may be periodically adjusted to reflect changes in provider coding patterns and case-mix and such other factors as may be determined by the commissioner;

(ii) Only those two thousand five base year costs which relate to the cost of services provided to Medicaid inpatients, as determined by the applicable ratio of costs to charges methodology, shall be utilized for rate-setting purposes, provided, however, that the commissioner may utilize updated Medicaid inpatient related base year costs and statistics as necessary to adjust inpatient rates in accordance with clause (C) of subparagraph (x) of this paragraph;

(iii) Such rates shall reflect the application of hospital specific wage equalization factors reflecting differences in wage rates;

(iv) Such rates shall reflect the utilization of the all patient refined (APR) case mix methodology, utilizing diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and the associated risk of mortality, and as may be periodically updated by the commissioner;

* (iv-a) Effective April first, two thousand twenty, such rates for public general hospitals or public health systems, other than those operated by the state of New York or the state university of New York, located in a city having a population of one million or more shall include a rate add-on that reflects reimbursement for costs, to the extent permitted under 42 CFR 447.272(b)(1) and based on actual utilization of services. Such rate add-on shall be contingent upon federal financial participation and approval, and subject to the terms of a binding memorandum of understanding executed between the department of health and the public general hospital or public health system receiving the rate add-on. If payment of such rate add-on is projected to cause Medicaid disbursements for such period to exceed the projected department of health Medicaid state funds in the enacted budget financial plan pursuant to subdivision three of section twenty-three of the state finance law, as determined by the director of the budget, or memorandum of understanding is not executed or is breached, the commissioner, in consultation with the director of budget, may either cancel or reduce payment of such rate add-on to achieve compliance with the enacted budget financial plan.

* NB Repealed March 31, 2029

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid

payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand fifteen, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand fifteen and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand fifteen; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand fifteen, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

(vi) Such regulations shall address adjustments based on the costs of high cost outlier patients;

(vii) Such rates shall continue to reflect trend factor adjustments as otherwise provided in paragraph (c) of subdivision ten of this section;

(viii) Such rates shall not include any adjustments pursuant to subdivision nine of this section;

(ix) Rates for non-public, not for profit general hospitals which have not, as of the effective date of this subdivision, published an ancillary charges schedule as provided in paragraph (j) of subdivision one of section twenty-eight hundred three of this article shall have their inlier payments increased by an amount equal to the average of cost outlier payments for comparable hospitals or by a methodology that uses a statewide or regional ratio of cost to charges applied to statewide or regional comparable charges for those cases determined by the commissioner;

(x) Such regulations shall provide for administrative rate appeals, but only with regard to: (A) the correction of computational errors or

omissions of data, including with regard to the hospital specific computations pertaining to graduate medical education, wage equalization factor adjustments, (B) capital cost reimbursement, and, (C) changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displaced and transferred as a result of teaching hospital closures;

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations. In addition, such regulations shall specify the reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided;

(xii) Such regulations may incorporate quality related measures pertaining to the inappropriate use of certain medical procedures, including, but not limited to, cesarean deliveries, coronary artery bypass grafts and percutaneous coronary interventions;

(xiii) Such regulations may impose a fee on general hospital sufficient to cover the costs of auditing the institutional cost reports submitted by general hospitals, which shall be deposited in the Health Care Reform Act (HCRA) resources account.

(c) 1. The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on or after April first, two thousand fourteen, but no later than July first, two thousand fourteen; and further provided that the updated base period subsequent to July first, two thousand eighteen shall begin on or after January first, two thousand twenty-four.

2. In the event of a declaration of a federal public health emergency, as defined in 42 USC § 247d, or a state disaster emergency, as defined in section twenty of the executive law, that severely impacts general

hospitals within the state, the department may exclude, for purposes of this paragraph, the audited reported costs and statistics during such declaration.

(d) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this subdivision shall remain subject to the provisions of subdivision eight of this section.

(e) The provisions of this subdivision shall not apply to those general hospitals or distinct units of general hospitals whose inpatient reimbursement does not, as of November thirtieth, two thousand nine, reflect case based payment per diagnosis-related group or whose inpatient reimbursement is, for periods on and after July first, two thousand nine, governed by the provisions of paragraphs (e-1) or (e-2) of subdivision four of this section.

(f) Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other law, rule or regulation to the contrary, the commissioner may contract with a vendor for consideration to develop the specifications for the diagnosis-related groups methodology as provided for in regulations promulgated pursuant to paragraph (b) of this subdivision if the commissioner certifies to the comptroller that such contract is in the best interest of the health of the people of the state. Notwithstanding that such specifications shall be available pursuant to article six of the public officers law, such contract may provide that the specifications for such adjusted or additional diagnosis-related groups provided by the vendor shall be subject to copyright protection pursuant to federal copyright law.

(g) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law, the commissioner may, for rate periods on and after December first, two thousand nine and subject to the availability of federal financial participation, make additional adjustments to the inpatient rates of payment of eligible general hospitals, to facilitate improvements in hospital operations and finances, in accordance with the following:

(i) General hospitals eligible for distributions pursuant to this paragraph shall be those non public hospitals with Medicaid discharges equal to or greater than seventeen and one-half percent for two thousand seven.

(ii) Funds distributed pursuant to this paragraph shall be allocated to eligible hospitals pursuant to a formula such that, to the extent of funds available, no hospital's reduction in Medicaid inpatient revenue as a result of the application of the provisions of paragraphs (a) and (b) of this subdivision exceeds a percentage reduction as determined by the commissioner.

(iii) Funding pursuant to this paragraph shall be available for the following periods and in the following amounts:

(A) for the period December first, two thousand nine through March thirty-first, two thousand ten, up to thirty-three million five hundred thousand dollars;

(B) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to seventy-five million dollars, provided, however, that, notwithstanding subparagraph (ii) of this paragraph, no facility shall receive an amount pursuant to this clause that is less than such facility received pursuant to clause (A) of this subparagraph;

(C) for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to fifty million dollars;

(D) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to twenty-five million dollars.

(iv) Payments made pursuant to this paragraph shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation.

(v) Each hospital receiving funds pursuant to this paragraph shall, as a condition for eligibility for such funds, adopt a resolution of the board of directors of each such hospital setting forth its current financial condition and a plan for reforming and improving such financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such board of directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report is not issued and adopted by each such board of directors, or if such report fails to set forth adequate progress, as determined by the commissioner, the commissioner may deem such facility ineligible for further distributions pursuant to this paragraph and may redistribute such further distributions to other eligible facilities in accordance with the provisions of this paragraph.

The commissioner shall be provided with copies of all such resolutions and reports.

(h) Inpatient rate adjustments made pursuant to paragraphs (a) through (f) of this subdivision after application of adjustments authorized pursuant to subdivision thirty-three of this section shall result in a net statewide decrease in aggregate Medicaid payments of no less than seventy-five million dollars for the period December first, two thousand nine through March thirty-first, two thousand ten, and no less than two hundred twenty-five million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven and each state fiscal year thereafter, provided, however, that such reductions shall be in addition to the reductions required pursuant to subparagraph (ii) of paragraph (a) of subdivision thirty-three of this section.

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

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

(A) Thirty percent of such payments shall be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(B) Seventy percent of such payments shall be allocated to eligible general hospitals based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(C) No eligible general hospital's annual payment amount pursuant to this paragraph shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of this article; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals pursuant to clauses (A) and (B) of this subparagraph in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to clauses (A) and (B) of

this subparagraph to the total of all payment amounts for such eligible hospitals;

(D) Subject to the availability of federal financial participation, the payment methodology set forth in this subparagraph may be further revised by the commissioner on an annual basis pursuant to regulations issued pursuant to this subdivision for periods on and after April first, two thousand eleven; and

(E) Subject to the availability of federal financial participation and in conformance with all applicable federal statutes and regulations, such payments shall be made as upper payment limit payments and, further, such payments shall be made as aggregate monthly payments to eligible general hospitals.

(ii) In the event that the commissioner determines that federal financial participation will not be available for aggregate payments made in accordance with clause (E) of subparagraph (i) of this paragraph, payments pursuant to this paragraph shall be included as rate add-ons to medical assistance inpatient rates of payment established pursuant to this subdivision based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year, provided, however, that if such payments are made as rate add-ons, the commissioner shall establish a procedure to reconcile payment amounts to reflect changes in medical assistance utilization from the period two years prior to the rate year and the actual rate year based on data as reported on each hospital's annual institutional cost report for the respective rate year, as submitted to the department as of October first of the year following the rate year.

(iii) Notwithstanding any other law, rule or regulation to the contrary, projections of each general hospital's disproportionate share limitations as computed by the commissioner pursuant to applicable regulations shall be adjusted to reflect any additional revenue received or anticipated to be received by each such general hospital pursuant to this paragraph.

(j) Notwithstanding any contrary provision of law, with regard to inpatient and outpatient Medicaid rates of payment for general hospital services, the commissioner may make such adjustments to such rates and to the methodology for computing such rates as is necessary to achieve

no aggregate, net increase or decrease in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system on or about October first, two thousand fourteen, as compared to such aggregate expenditures from the twelve-month period immediately prior to such implementation.

§ 2807-d. Hospital assessments. 1. (a) Hospitals, as defined in this article, excluding hospitals specified in paragraph (b) of this subdivision, are charged assessments on their gross receipts received from all patient care services and other operating income, less personal needs allowances and refunds, on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted by or on behalf of hospitals to the commissioner or his designee.

(b) Subject to the provisions of subdivision twelve of this section, the following categories of hospitals shall not be charged assessments pursuant to this section: (i) voluntary nonprofit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article, or for assessments during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven voluntary nonprofit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five; (ii) voluntary nonprofit hospitals totally financed by charitable contributions or by the income thereon dedicated to free care of low income patients; and (iii) any facility dedicated solely to the care of police, firefighters, volunteer firefighters, and emergency service personnel.

(c) On and after December first, nineteen hundred ninety-seven, the term "general hospital", as used in this section, includes specialty hospitals for persons who are developmentally disabled, licensed by the office for people with developmental disabilities and which are also issued an operating certificate pursuant to section twenty-eight hundred five of this article.

2. (a) (i) For general hospitals the overall assessment shall be six-tenths of one percent and the assessment shall vary from 0.5% to 0.675% of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis during the period January first, nineteen hundred ninety-one through March thirty-first, nineteen hundred ninety-two for hospital or health-related services, including but not limited to inpatient service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service. The assessment shall vary according to the percentage of nineteen hundred eighty-nine medicaid inpatient revenues as a percentage of total nineteen hundred eighty-nine inpatient revenues as reported on the institutional cost report submitted to the department for nineteen hundred eighty-nine according to the following: for hospitals with medicaid revenue up to and including 10%, the assessment shall be .5%, for hospitals with medicaid revenue greater than 10% up to and including 15%, the assessment shall be .525%, for hospitals with medicaid revenue greater than 15% up to and including 20%, the assessment shall be .65%, and for hospitals with medicaid revenue over 20%, the assessment shall be .675%. In the event that the provisions relating to the additional supplementary low income patient adjustment established in accordance with subdivision fourteen-d of section twenty-eight hundred seven-c of this article cannot be implemented, then the general hospital assessment established in accordance with this paragraph shall be calculated without variation specified in this paragraph and the assessment for each general hospital whose assessment was greater than six-tenths of one percent shall become six-tenths of one percent.

(ii) For general hospitals the assessment shall be six-tenths of one percent of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-two for hospital or health-related services, including, but not limited to inpatient service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service; provided, however, that for all such gross receipts received on or after December first, nineteen hundred ninety-eight, such assessment shall be two-tenths of one

percent, and further provided that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be one-tenth of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(iii) For general hospitals an additional assessment shall be one-tenth of one percent of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-two for hospital or health-related services, including, but not limited to inpatient service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service; provided, however, that such additional assessment shall expire and be of no further effect for all such gross receipts received on or after December first, nineteen hundred ninety-seven.

(iv) Subject to the provisions of subdivision twelve of this section, the assessment and additional assessment pursuant to subparagraphs (ii) and (iii) of this paragraph during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight for voluntary nonprofit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five shall be abated by seventy-five percent, and during the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine shall be abated by twenty-five percent.

(v) Notwithstanding any contrary provisions of this paragraph or any other provision of law or regulation, for general hospitals the assessment shall be thirty-five hundredths of one percent of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand five through March thirty-first two thousand seven for hospital or health-related services, including, but not limited to inpatient service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical services, but not including residential health care facilities services or home health care

services.

(vi) Notwithstanding any contrary provisions of this paragraph or any other provision of law or regulation, for general hospitals the assessment shall be thirty-five hundredths of one percent of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis for periods on and after April first, two thousand nine, for hospital or health-related services, including, but not limited to inpatient services, outpatient services, emergency services, referred ambulatory services and ambulatory surgical services, but not including residential health care facilities services or home health care services.

(b) (i) For residential health care facilities the assessment shall be six-tenths of one percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-one for hospital or health-related services, including adult day services; provided, however, that for all such gross receipts received on or after September first, nineteen hundred ninety-seven such assessment shall be three-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after December first, nineteen hundred ninety-eight.

(ii) For residential health care facilities an additional assessment shall be one and two-tenths percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-two for hospital or health-related services, including adult day services; provided, however, that such additional assessment shall expire and be of no further effect for all such gross receipts received on or after April first, nineteen hundred ninety-nine.

(iii) For residential health care facilities a further additional assessment shall be three and eight tenths percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period of July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six for hospital or health-related services, including adult day services. The residential health care facility shall

file the assessment return with any balance due or any refund claimed by May first, nineteen hundred ninety-six. Notwithstanding any inconsistent provision of this section, the residential health care facility shall make estimated payments to the commissioner on a monthly basis starting August fifteenth, nineteen hundred ninety-five and continuing on the fifteenth of each month through March fifteenth, nineteen hundred ninety-six equal to one-eighth of the total estimated for this further additional assessment for the further additional assessment period. If the total of estimated payments is less than ninety-five percent of the actual payment due, the residential health care facility shall pay to the commissioner a penalty of fifteen percent of the difference due for each month in addition to the amount due. The commissioner may recoup deficiencies and penalties pursuant to paragraph (c) of subdivision six of this section.

* (iv) For residential health care facilities a further additional assessment shall be one and nine-tenths percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period of April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven for hospital or health-related services, including adult day services. The residential health care facility shall file the assessment return with any balance due or any refund claimed by May first, nineteen hundred ninety-seven. Notwithstanding any inconsistent provision of this section, the residential health care facility shall make estimated payments to the commissioner on a monthly basis starting May fifteenth, and continuing on the fifteenth of each month through March fifteenth equal to one-eleventh of the total estimated for this further additional assessment for the period April first, nineteen hundred ninety-six through March thirty-first nineteen hundred ninety-seven. If the total of estimated payments is less than ninety-five percent of the actual payment due, the residential health care facility shall pay to the commissioner a penalty of fifteen percent of the difference due each month in addition to the amount due. The commissioner may recoup deficiencies and penalties pursuant to paragraph (c) of subdivision six of this section.

* NB There are 2 subpar (iv)'s

* (iv) For residential health care facilities a further additional

assessment shall be one and nine-tenths percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period of April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven for hospital or health-related services, including adult day services. The residential health care facility shall file the assessment return with any balance due or any refund claimed by May first, nineteen hundred ninety-seven. Notwithstanding any inconsistent provision of this section, the residential health care facility shall make estimated payments to the commissioner on a monthly basis starting May fifteenth, and continuing on the fifteenth of each month through March fifteenth, equal to one-eleventh of the total estimated for this further additional assessment for the period beginning April first of nineteen hundred ninety-six and ending March thirty-first, nineteen hundred ninety-seven. If the total of the eleven required estimated payments is less than ninety-five percent of the actual payment due, the residential health care facility shall pay to the commissioner a penalty of fifteen percent of the difference due for each month in addition to the amount due. The commissioner may recoup deficiencies and penalties pursuant to paragraph (c) of subdivision six of this section.

* NB There are 2 subpar (iv)'s

* (v) For residential health care facilities in addition a further additional assessment shall be (a) two and three-tenths percent of each residential care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning May first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six for hospital or health-related services, including adult day services and (b) one and nine-tenths percent of each residential care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-seven and ending February twenty-eighth, nineteen hundred ninety-seven for hospital or health-related services, including adult day services.

* NB There are 2 subpar (v)'s

* (v) For residential health care facilities in addition a further additional assessment shall be (a) two and three-tenths percent of each

residential care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning May first, nineteen hundred ninety-six and ending December thirty-first, nineteen hundred ninety-six for hospital or health-related services, including adult day services and (b) one and nine-tenths percent of each residential care facility's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-seven and ending February twenty-eighth, nineteen hundred ninety-seven for hospital or health-related services, including adult day services; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-seven, such further additional assessment shall be three and six-tenths percent, and further provided that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such further additional assessment shall be two and four-tenths percent, and further provided that such further additional assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

* NB There are 2 subpar (v)'s

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

received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand twenty-one through March thirty-first, two thousand twenty-three such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand twenty-three through March thirty-first, two thousand twenty-five such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand twenty-five through March thirty-first, two thousand twenty-nine such assessment shall be six percent.

(c) For all other facilities issued an operating certificate pursuant to section twenty-eight hundred five of this article, including diagnostic and treatment centers, the assessment shall be six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one for hospital or health-related services, including diagnostic and treatment center services; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

3. Gross receipts received from all patient care services and other

operating income for purposes of the assessment pursuant to this section shall include, but not be limited to:

(a) for general hospitals, all monies received for or on account of inpatient hospital service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service, or other hospital or health-related services, excluding, subject to the provisions of subdivision twelve of this section: distributions from bad debt and charity care regional pools, primary health care services regional pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with section twenty-eight hundred seven-c of this article and the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c, the adjustment provided in accordance with subdivision fourteen-a, the adjustment provided in accordance with subdivision fourteen-d, the adjustment for health maintenance organization reimbursement rates provided in accordance with section twenty-eight hundred seven-f of this article, the adjustment for commercial insurer reimbursement rates provided in accordance with paragraph (i) of subdivision eleven of section twenty-eight hundred seven-c of this article or, if effective, the adjustment provided in accordance with subdivision fifteen of section twenty-eight hundred seven-c of this article or the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended and physician practice or faculty practice plan revenue received by a general hospital based on discrete billings for private practicing physician services, revenue received by a general hospital from a public hospital pursuant to an affiliation agreement contract for the delivery of health care services to such public hospital, revenue received pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, revenue received pursuant to section twenty-eight hundred seven-w of this article, all revenue received as disproportionate share hospital payments, in accordance with title nineteen of the federal Social Security Act, revenue received pursuant to sections eleven, twelve, thirteen and fourteen of part A of chapter one of the laws of two thousand two, revenue received pursuant to

sections thirteen and fourteen of part B of chapter one of the laws of two thousand two, revenue from patient personal fund allowances, revenue from income earned on patient funds, investment income from externally restricted funds, revenue from investment sinking funds, revenue from investment operating escrow accounts, investment income from funded depreciation, investment income from mortgage repayment escrow accounts, revenue derived from the operation of schools leading to licensure, and revenue from the collection of sales and excise taxes;

(b) for residential health care facilities, all monies received for or on account of hospital or health-related service, including adult day services, excluding subject to the provisions of subdivision twelve of this section the component of rates of payment related to the adjustment provided in accordance with subdivision twelve of section twenty-eight hundred eight of this article;

(c) for all other facilities issued an operating certificate pursuant to section twenty-eight hundred five of this article, including diagnostic and treatment centers, all monies received for or on account of hospital or health-related services, however, subject to the provisions of subdivision twelve of this section, excluding the component of rates of payment related to the allowance provided in accordance with paragraph (f) of subdivision two of section twenty-eight hundred seven of this article, excluding for a diagnostic and treatment center operated by a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law monies received for or on account of services provided to subscribers of such health maintenance organization and excluding patient care services which if provided to persons eligible for medical assistance pursuant to title eleven of article five of the social services law would be eligible for ninety percent federal funds as set forth in section nineteen hundred three of the federal social security act; and

(d) for all hospitals, excluding diagnostic and treatment centers operated by a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law, shall include monies received for or on account of such revenue sources as investment income, parking lots, cafeterias, gift shops and rental income, provided, however, that

subject to the provisions of subdivision twelve of this section income received from grants, charitable contributions, donations and bequests and governmental deficit financing and the component of rates of payment reflecting any cost of the assessment reimbursable pursuant to subdivision ten of this section shall not be included.

4. For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or if not available such other administrators as the commissioner shall designate, to receive and distribute hospital assessment funds. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the assessment funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis four hundred thousand dollars for all assessments established pursuant to this section, shall be paid from the assessment funds.

5. Estimated payments by or on behalf of hospitals to the commissioner or his designee of funds due from the assessments pursuant to subdivision two of this section shall be made on a monthly basis. Estimated payments shall be due on or before the fifteenth day following the end of a calendar month to which an assessment applies.

6. (a) If an estimated payment made for a month to which an assessment applies is less than seventy percent of an amount the commissioner determines is due, based on evidence of prior period moneys received by a hospital or evidence of moneys received by such hospital for that month, the commissioner may estimate the amount due from such hospital and may collect the deficiency pursuant to paragraph (c) of this subdivision.

(b) If an estimated payment made for a month to which an assessment applies is less than ninety percent of an amount the commissioner determines is due, based on evidence of prior period moneys received by a hospital or evidence of moneys received by such hospital for that month, and at least two previous estimated payments within the preceding

six months were less than ninety percent of the amount due, based on similar evidence, the commissioner may estimate the amount due from such hospital and may collect the deficiency pursuant to paragraph (c) of this subdivision.

(c) Upon receipt of notification from the commissioner of a hospital's deficiency under this section, the comptroller or a fiscal intermediary designated by the director of the budget, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law, or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or by such article forty-three corporation or article forty-four organization to the hospital the amount of the deficiency determined under paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section. Upon withholding such amount, the comptroller or a designated fiscal intermediary, or the commissioner of social services, or corporation organized and operating in accordance with article forty-three of the insurance law or organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld on behalf of the hospital.

(d) The commissioner shall provide a hospital with notice of any estimate of an amount due for an assessment pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section at least three days prior to collection of such amount by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(e) In the event a hospital objects to an estimate by the commissioner pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section of the amount due for an assessment, the hospital, within sixty days of notice of an amount due, may request a public hearing. If a hearing is requested, the commissioner shall provide the hospital an opportunity to be heard and to present evidence bearing on the amount due for an assessment within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. An administrative hearing is not a prerequisite to seeking judicial relief.

(f) The commissioner may direct that a hearing be held without any

request by a hospital.

7. (a) Every hospital shall submit reports on a cash basis of actual gross receipts received from all patient care services and operating income for each month as follows:

(i) for the period January first, nineteen hundred ninety-one through January thirty-first, nineteen hundred ninety-one, the report shall be filed on or before March fifteenth, nineteen hundred ninety-one; and

(ii) for the quarter year ending March thirty-first, nineteen hundred ninety-one and for each quarter thereafter, the report shall be filed on or before the forty-fifth day after the end of such quarter.

(b) Every hospital shall submit a certified annual report on a cash basis of gross receipts received in such calendar year from all patient care services and operating income.

(c) The reports shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section, provided, however, that for periods on and after July first, two thousand twelve, such reports and any associated certifications shall be submitted electronically in a form as may be required by the commissioner.

(d) Final payments shall be due for all hospitals for the assessments pursuant to subdivision two of this section upon the due date for submission of the applicable quarterly report.

(e) The commissioner may recoup deficiencies in final payments pursuant to paragraph (c) of subdivision six of this section. Delinquent amounts which have been referred for recoupment or offset pursuant to paragraph (c) of subdivision six of this section, or which have been referred to the office of the attorney general for collection, shall be deemed final and not subject to further revision or reconciliation by the commissioner based on any additional reports or other information submitted by the hospital, provided, however, that such delinquencies shall not be referred for such recoupment or for such collection based on estimated amounts unless the hospital has received written notification of such delinquencies and has been given no less than thirty days in which to submit delinquent reports.

(f) Payments and reports submitted or required to be submitted to the commissioner or to the commissioner's designee pursuant to this section

shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made to subsequent payments made pursuant to this section, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year period, or from conducting an audit of any adjustment or reconciliation made by a hospital.

8. (a) If an estimated payment made for a month to which an assessment applies is less than ninety percent of the actual amount due for such month, interest shall be due and payable to the commissioner on the difference between the amount paid and the amount due from the day of the month the estimated payment was due until the date of payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest, if not paid by the due date of the following month's estimated payment, may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

(b) If an estimated payment made for a month to which an assessment applies is less than seventy percent of the actual amount due for such month, a penalty shall be due and payable to the commissioner of five percent of the difference between the amount paid and the amount due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

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

9. Funds accumulated, including income from invested funds, from the assessments specified in this section, including interest and penalties, shall be deposited by the commissioner and:

(a) credited to the general fund;

(b) provided, however, that funds accumulated, including income from invested funds, from the assessments provided in accordance with subparagraph (v) of paragraph (a) and subparagraphs (iii), (iv), (v) and (vi) of paragraph (b) of subdivision two of this section, including interest and penalties, shall be deposited by the commissioner and credited to the special revenue fund-other, miscellaneous special revenue fund (339), medical assistance account. To the extent of funds appropriated therefor, funds shall be made available for payments under the medical assistance program provided pursuant to title eleven of article five of the social services law;

(c) and provided further, however, that funds accumulated, including income from invested funds, for a period from the assessment and additional assessment provided in accordance with subparagraphs (ii) and (iii) of paragraph (a) of subdivision two of this section, including interest and penalties, on voluntary nonprofit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five shall be transferred by the commissioner and consolidated with funds accumulated from the allowance pursuant to subdivision two of section twenty-eight hundred seven-j of this article for such period and allocated in accordance with subdivision nine of section twenty-eight hundred seven-j of this article.

10. Notwithstanding any inconsistent provision of law or regulation to the contrary:

(a) the assessments pursuant to this section shall not be an allowable cost in the determination of reimbursement rates pursuant to this article;

(b) provided, however, that for purposes of determining rates of payment pursuant to this article for residential health care facilities, for the period January first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-nine, the additional assessment of one and two-tenths percent, and for the period July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six the further additional assessment of three and eight-tenths percent, and for the period April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven the further additional assessment of one and nine-tenths percent, and for the period May first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six the further additional assessment of two and three-tenths percent and for the period January first, nineteen hundred ninety-seven through February twenty-eighth, nineteen hundred ninety-seven the further additional assessment of one and nine-tenths percent, and for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine the further additional assessment of three and six-tenths percent, and for the period April first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine the further additional assessment of two and four-tenths percent, imposed pursuant to this section shall be a reimbursable cost to be reflected as timely as practicable in rates of payment applicable within the assessment period, contingent, for payments by governmental agencies, on all federal approvals necessary by federal law and regulations for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act.

(c) provided, however, that for the purposes of determining rates of payment pursuant to this article for residential health care facilities, the assessment imposed pursuant to subparagraph (vi) of paragraph (b) of subdivision two of this section shall be a reimbursable cost to be

reflected as timely as practicable, and subsequently reconciled to actual cost, in rates of payment applicable within the assessment period, provided further, however, that insofar as such assessment is in excess of six percent it shall not be deemed a reimbursable cost and shall not be reflected in such rates of payment.

(d) provided, however, that the adjustment to rates of payment made pursuant to paragraph (c) of this subdivision shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to title XVIII of the federal social security act (medicare) units of service.

(e) the provisions of paragraphs (c) and (d) of this subdivision shall each be contingent upon receipt of all federal approvals required by federal law and regulations for federal financial participation in payments made in accordance with paragraphs (c) and (d) of this subdivision.

11. (a) (ii) The assessment shall not be collected in excess of one hundred thirty-four million three hundred thousand dollars from general hospitals for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight. The amount of the assessment collected pursuant to paragraph (a) of subdivision two of this section in excess of one hundred thirty-four million three hundred thousand dollars for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight shall be refunded to general hospitals by the commissioner based on the ratio which a general hospital's assessment for such period bears to the total of the assessments for such period paid by general hospitals.

(iii) The additional assessment shall not be collected in excess of fourteen million nine hundred thousand dollars from general hospitals for the period of April first, nineteen hundred ninety-seven through November thirtieth, nineteen hundred ninety-seven. The amount of the additional assessment collected pursuant to paragraph (a) of subdivision two of this section in excess of fourteen million nine hundred thousand dollars for the period of April first, nineteen hundred ninety-seven through November thirtieth, nineteen hundred ninety-seven shall be refunded to general hospitals by the commissioner based on the ratio which a general hospital's additional assessment for such period bears

to the total of the additional assessments for such period paid by general hospitals.

(b) (ii) The assessment shall not be collected in excess of fifteen million dollars from residential health care facilities for the period of April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine. The amount of the assessment collected pursuant to paragraph (b) of subdivision two of this section in excess of fifteen million dollars for the period of April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's assessment for such period bears to the total of the assessments for such period paid by residential health care facilities.

(iii) The additional assessment shall not be collected in excess of eighty-nine million nine hundred thousand dollars from residential health care facilities for the period of April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine. The amount of the additional assessment collected pursuant to paragraph (b) of subdivision two of this section in excess of eighty-nine million nine hundred thousand dollars for the period of April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's additional assessment for such period bears to the total of the additional assessments for such period paid by residential health care facilities.

(iv) The further additional assessment shall not be collected in excess of one hundred sixty-four million seven hundred thousand dollars from residential health care facilities for the period July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six. The amount of the further additional assessment collected pursuant to paragraph (b) of subdivision two of this section in excess of one hundred sixty-four million seven hundred thousand dollars for the period of July first, nineteen hundred ninety-five through March thirtyfirst, nineteen hundred ninety-six shall be refunded to residential health care facilities by the commissioner based on the

ratio which a residential health care facility's further additional assessment for such period bears to the total of the further additional assessments for such period paid by residential health care facilities.

(v) The further additional assessment imposed pursuant to subparagraph (iv) of paragraph (b) of subdivision two of this section shall not be collected in excess of one hundred twelve million dollars from residential health care facilities for the period April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven. The amount of the further additional assessment collected pursuant to subparagraph (iv) of paragraph (b) of subdivision two of this section in excess of one hundred twelve million dollars for the period of April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's further additional assessment for such period bears to the total of the further additional assessments for such period paid by residential health care facilities.

(vi) The further additional assessment shall not be collected in excess of one hundred ten million dollars from residential health care facilities for the period May first, nineteen hundred ninety-six through February twenty-eighth, nineteen hundred ninety-seven. The amount of the further additional assessment collected pursuant to subparagraph (v) of paragraph (b) of subdivision two of this section in excess of one hundred ten million dollars for the period May first, nineteen hundred ninety-six through February twenty-eighth, nineteen hundred ninety-seven shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's further additional assessment for such period bears to the total of the further additional assessments for such period paid by residential health care facilities.

(vii) The further additional assessment shall not be collected in excess of two hundred forty million dollars from residential health care facilities for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight. The amount of the further additional assessment collected pursuant to subparagraph (v) of paragraph (b) of subdivision two of this section in excess of two hundred forty million dollars for the period of April first, nineteen

hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's further additional assessments for such a period bears to the total of the further additional assessments for such period paid by residential health care facilities.

(viii) The further additional assessment shall not be collected in excess of two hundred fifty-six million eight hundred thousand dollars from residential health care facilities for the period April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine. The amount of the further additional assessment collected pursuant to subparagraph (v) of paragraph (b) of subdivision two of this section in excess of two hundred fifty-six million eight hundred thousand dollars for the period April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine shall be refunded to residential health care facilities by the commissioner based on the ratio which a residential health care facility's further additional assessments for such period bears to the total of the further additional assessments for such period paid by residential health care facilities.

(c) (ii) The assessment shall not be collected in excess of seven million four hundred thousand dollars from all other facilities issued an operating certificate pursuant to section twenty-eight hundred five of this article for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight. The amount of the assessment collected pursuant to paragraph (c) of subdivision two of this section in excess of seven million four hundred thousand dollars for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight shall be refunded by the commissioner based on the ratio which a facility's assessment for such period bears to the total of the assessments for such period paid by such facilities.

12. (a) Each exclusion of hospitals or sources of gross receipts received from the assessments effective on or after April first, nineteen hundred ninety-two, and prior to April first, two thousand two, established pursuant to this section shall be contingent upon either:

(i) qualification of the assessments for waiver pursuant to federal law and regulation; or (ii) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the assessments relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the assessments do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of April first, nineteen hundred ninety-two, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the hospital pays the retroactive amount due within ninety days of notice from the commissioner to the hospital that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner to the hospital.

(b) The exclusion of the hospitals described in paragraph (b) of subdivision one of this section and the exclusion of revenue described in subdivision two of this section from the assessments set forth in subdivision two of this section for periods on and after April first, two thousand two shall be contingent upon either: (i) qualification of the assessments for waiver pursuant to federal law and regulation; or (ii) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect such assessments relying on such exclusion, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that such assessments do not so qualify based on such

exclusion, then the commissioner shall, to the extent necessary to achieve such qualification for federal financial participation, deem such exclusions null and void as of the first day of the period for which such assessments apply, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the hospital pays the retroactive amount due within ninety days of notice from the commissioner to the hospital that such exclusion is null and void.

(c) No hospital shall be obligated to pay assessments pursuant to subparagraph (v) of paragraph (a) of subdivision two of this section prior to December first, two thousand five. The commissioner shall collect payment obligations incurred prior to December first, two thousand five proportionally over the remaining months in the state fiscal year.

§ 2807-dd. Temporary nursing home stability contributions. 1.

Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals or waivers, for periods on and after April first, two thousand eleven, a temporary nursing home stability contribution shall be imposed on the gross receipts of each residential health care facility equal to four tenths of one percent of such receipts and provided further, however, that on and after April first, two thousand twelve through October thirty-first, two thousand twelve such contributions shall be reduced to two tenths of one percent, and provided further, however, that on and after November first, two thousand twelve, such contributions shall be reduced to zero.

2. The gross receipts subject to this section shall be as defined in paragraph (b) of subdivision three of section twenty-eight hundred seven-d of this article and shall include income from all patient care services and other operating income on a cash basis, but excluding revenue received pursuant to the federal Medicare program. The contributions described in this section shall be administered in accordance with and subject to the provisions of subdivisions four, five, six, seven, eight, nine and twelve of section twenty-eight hundred seven-d of this article, provided, however, that such contributions

shall not be an allowable cost in the determination of reimbursement rates of payment computed pursuant to this article.

§ 2807-d-1. Hospital quality contributions. 1. Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals or waivers, for periods on and after July first, two thousand eleven, a quality contribution shall be imposed on the inpatient revenue of each general hospital that is received for the provision of inpatient obstetrical patient care services in an amount equal to one and six-tenths percent of such revenue, as defined in accordance with paragraph (a) of subdivision three of section twenty-eight hundred seven-d of this article, provided, however, that in the event the commissioner, in consultation with the director of the budget, determines that such quality contribution shall raise less than or more than the total quality collection amount set forth in subdivision two of this section, the commissioner, in consultation with the director of the budget, may promulgate regulations, and may promulgate emergency regulations, increasing or decreasing such quality contributions by amounts sufficient to ensure the collection of such annual quality contribution amount.

2. The annual quality contribution amount referenced in subdivision one of this section shall be thirty million dollars for the state fiscal year beginning April first, two thousand eleven, and for each subsequent state fiscal year thereafter it shall be the amount of the preceding year as increased by the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years.

3. The quality contributions described in this section shall be administered in accordance with and subject to the provisions of subdivisions four, five, six, seven, eight and twelve of section twenty-eight hundred seven-d of this article, provided, however, that such quality contributions shall be deposited in the HCRA resources fund as established pursuant to section ninety-two-dd of the state finance

law; and provided further, however, that such contributions shall not be an allowable cost in the determination of reimbursement rates of payment computed pursuant to this article.

§ 2807-e. Uniform bills. 1. Definitions. For the purposes of this section, unless the context clearly requires otherwise:

(a) "Ambulatory care services" shall mean ambulatory surgical services, diagnostic and treatment services, emergency services, hospital outpatient services and physician services.

(b) "Superintendent" shall mean the superintendent of financial services.

(c) "Third-party payor" shall mean those payors within the payor categories specified in paragraphs (a) and (b) of subdivision one of section twenty-eight hundred seven-c of this article, except for payments made for persons who are eligible as beneficiaries of title XVIII of the federal social security act (medicare).

(d) "Bill," other than a patient bill, shall include a claim form for a third-party payor.

2. Uniform bills. (a) Notwithstanding any inconsistent provisions of law, the commissioner shall, on or after July first, nineteen hundred ninety-five, develop a uniform patient bill for the purpose of providers providing a health care consumer with a patient bill for hospital and health-related services, in consultation with the superintendent of financial services, statewide organizations representative of providers of hospital and health-related services, third-party payors as described in paragraphs (a) and (b) of subdivision one of section two thousand eight hundred seven-c of this article, and representatives of health care consumers. Such patient bill shall be in such form and shall contain such information as may be required in accordance with rules and regulations developed by the commissioner, provided that distinct uniform patient bills may be developed for each type or level of health-related service.

(b) No provider of hospital or health-related services shall provide a health care consumer with any patient bill, on or after September first, nineteen hundred ninety-five, for services provided to such consumer

except such uniform patient bill as developed by the commissioner pursuant to paragraph (a) of this subdivision.

(c) Notwithstanding any inconsistent provision of this article or any other law, beginning on or after April first, nineteen hundred ninety-four, each general hospital providing inpatient services shall use a uniform data set, developed by the commissioner in consultation with representatives of providers and third-party payors, for the purpose of billing a third-party payor for inpatient services containing such information as may be required in accordance with rules and regulations of the commissioner.

(d) Notwithstanding any inconsistent provision of this article or any other law, beginning on or after September first, nineteen hundred ninety-four, each general hospital, diagnostic and treatment center, or ambulatory surgery center providing ambulatory care services shall use a uniform bill, developed by the commissioner in consultation with representatives of providers and third-party payors, for the purpose of billing a third-party payor for ambulatory care services containing such information as may be required in accordance with rules and regulations of the commissioner.

(e) Notwithstanding any inconsistent provision of this article or any other law, beginning on or after January first, nineteen hundred ninety-five, each physician providing physician services shall use a uniform bill, developed by the commissioner in consultation with representatives of providers and third-party payors, for the purpose of billing a third-party payor for physician services containing such information as may be required in accordance with rules and regulations of the commissioner.

(f) Notwithstanding any inconsistent provision of this article or any other law, the commissioner in consultation with the superintendent and the commissioner of social services shall establish procedures for requiring any payor for inpatient services, ambulatory care services or physician services making payment pursuant to the provisions of this section to utilize a uniform bill for patient services required pursuant to paragraphs (c), (d) and (e) of this subdivision.

* 3. Fiscal intermediary. Notwithstanding any inconsistent provision of law, the commissioner shall not enter into an agreement for a pilot program which provides for among its purposes a single fiscal

intermediary for the processing of hospital bills in a region, unless the commissioner shall first notify the chairs of the senate and assembly standing committees on health not less than one hundred twenty-days prior to entering into such agreement. Such notification shall include, but need not be limited to, the following:

- (a) the source of funding and anticipated expenditures for such program;
- (b) the geographic region and participants in such program;
- (c) the nature and policy objectives of such program, including its relationship to long range policy objectives, and including but not limited to its relationship to establishing a universal health insurance coverage system;
- (d) a discussion of the design, proposed implementation, and time-frames for such program; and
- (e) a copy of any proposed agreements or other contractual arrangements relating to the program.

In the event the commissioner subsequently enters into an agreement for such a pilot program the commissioner shall promptly provide a copy of such agreement to such chairs. The commissioner shall report every six months thereafter on the progress of implementation of such program and provide a final evaluation of the program upon its conclusion.

* NB Expired July 1, 2017

4. Electronic transfer of claims information. (a) Claims submitted to third-party payors for payment for inpatient hospital services provided by a general hospital on or after April first, nineteen hundred ninety-four shall be submitted in electronic formats consistent with this section.

(b) Claims for payment made to third-party payors for ambulatory care services provided by a general hospital, diagnostic and treatment center or ambulatory surgery center on or after January first, nineteen hundred ninety-five shall be submitted in electronic formats consistent with this section.

(c) Claims for payment made to third-party payors for physician services on or after July first, nineteen hundred ninety-five shall be submitted in electronic formats consistent with this section.

(d) The provisions of this section shall not apply to claims for payment to third-party payors for which the content, processing and payment thereof are regulated solely by federal law or regulation, provided, however that such third-party payors may voluntarily participate in the electronic submission of claims information.

(e) Consistent with their capabilities hospitals, diagnostic and treatment centers, physicians, other practitioners and third-party payors may be permitted to elect to submit claims information electronically prior to the above dates.

(f) The commissioner shall delay or waive the implementation of this section in particular instances for diagnostic and treatment centers or practitioners and, in consultation with the superintendent, third-party payors where such diagnostic and treatment centers, practitioners or third-party payors have a small volume of services or business.

(g) The commissioner, in consultation with the superintendent and the commissioner of social services, shall establish procedures for requiring third-party payors to accept the electronic submission of claims information for inpatient or ambulatory care services made pursuant to the provision of this section.

5. The commissioner, in consultation with the superintendent, shall make recommendations, to the legislature, by June thirtieth, nineteen hundred ninety-four, for improving the efficiency of processing electronic claims by health care providers and third-party payors; including but not limited, to the use of electronic claims clearing-house.

§ 2807-f. Health maintenance organization payment factor. 1. For purposes of this section, the following terms shall have the following meaning:

(a) "HMO" shall mean a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law.

(b) "Medicaid" shall mean the medical assistance program established pursuant to title eleven of article five of the social services law.

2. For periods commencing on or after July first, nineteen hundred ninety-eight, an HMO payment factor shall be determined in accordance with subdivision three of this section. Such subdivision shall apply during the period July first, nineteen hundred ninety-eight through June thirtieth, nineteen hundred ninety-nine; provided, however, that this section shall expire and be deemed repealed on and after the date on which New York state is granted the authority, by federal waiver, agreed upon by the state and the secretary of the federal department of health and human services, or federal statute, to operate a mandatory medicaid managed care program.

3. (a) In recognition of the public benefits resulting from enrolling medicaid enrollees into managed care plans, HMOs are required to make a good faith effort to enroll medicaid recipients. A good faith effort shall be defined as:

(i) submitting a reasonable bid in response to a state or county procurement process;

(ii) willingness to enter into reasonable managed care contracts with counties in its approved service area;

(iii) demonstrating a willingness to enroll medicaid recipients including accepting referrals from counties, brokers and auto-assignments; and

(iv) such other factors as may be established by the commissioner.

(b) In the event that an HMO has not made a good faith effort to enroll medicaid recipients, the commissioner shall impose a payment factor of nine percent on payments to general hospitals for the calendar year by such HMO. The commissioner shall notify HMOs of any failure to make a good faith effort and the application of the payment factor by November first preceding the applicable calendar year.

4. (a) Each HMO on behalf of general hospitals shall pay into a statewide health maintenance organization pool created by the commissioner the factor established pursuant to subdivision two or three and this subdivision for each patient discharged in the previous calendar month commencing with July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine or contracted hospital inpatient service obligations for periods on or

after July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine. Funds accumulated in the pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

(b) Payments by HMOs to the pool shall be due on or before the fifteenth day following the end of each month.

(c) (i) If a payment made for a month to which a payment factor applies is less than ninety percent of the actual amount due for such month, interest shall be due and payable to the commissioner by a health maintenance organization on the difference between the amount paid and the amount due from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or, if greater, at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

(ii) If a payment made for a month to which a payment factor applies is less than seventy percent of the actual amount due for such month, a penalty shall be due and payable to the commissioner by a health maintenance organization of five percent of the difference between the amount paid and the amount due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate.

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

(d) The commissioner is authorized to contract with a pool

administrator designated for purposes of administering pools pursuant to subdivision two-a of section twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six, or if not available such other administrators as the commissioner shall designate, to receive and distribute health maintenance organization pool funds. In the event contracts are effectuated, the commissioner shall conduct or cause to be conducted annual audits of the receipt and distribution of the pool funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars, shall be paid from the pooled funds.

5. Payment factors established pursuant to this section shall not apply to payments for subscribers who are eligible for medical assistance pursuant to the social services law, participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight or successor insurance programs, and enrollees in the child health insurance program pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this title.

6. Notwithstanding any inconsistent provisions of the state administrative procedure act or any other provision of law, the commissioner is authorized to adopt or amend on an emergency basis any regulation he or she determines necessary to implement this section.

7. HMOs shall provide to the commissioner such information as the commissioner may require to effectuate the provisions of this section.

§ 2807-ff. New York managed care organization provider tax. 1. The commissioner, subject to the approval of the director of the budget, shall: apply for a waiver or waivers of the broad-based and uniformity requirements related to the establishment of a New York managed care organization provider tax (the "MCO provider tax") in order to secure federal financial participation for the costs of the medical assistance program; and, subject to approval by the centers for Medicare and

Medicaid services, impose the MCO provider tax as an assessment upon insurers, health maintenance organizations, and managed care organizations (collectively referred to as "health plan") offering the following plans or products:

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

(b) A health insurance plan serving individuals enrolled pursuant to title one-A of article twenty-five of this chapter;

(c) Essential plan coverage certified pursuant to title eleven-D of article five of the social services law;

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

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

1-a. On or after April first, two thousand twenty-six, the commissioner, subject to the approval of the director of the budget, shall apply for an amendment of the MCO provider tax, subject to approval by the centers for Medicare and Medicaid services, to impose an amended MCO provider tax as an assessment upon health plans no sooner than January first, two thousand twenty-seven, as established in paragraph (b) of subdivision four of this section.

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

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

4. (a) Prior to January first, two thousand twenty-seven, a health plan, as defined in subdivision one of this section, shall pay the MCO provider tax for each calendar year as follows:

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

member month;

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

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

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

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

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

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

(b) Effective January first, two thousand twenty-seven, subject to any required approvals by the centers for Medicare and Medicaid services, a health plan, as defined in subdivision one of this section, shall pay the MCO provider tax for each calendar year at a rate of 0.35% of the health plan's total premium revenue.

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

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

7. (a) Every health plan subject to the approved MCO provider tax

shall submit reports in a form prescribed by the commissioner to accurately disclose information required to implement this section.

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

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

(b) The commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan has demonstrated that imposition of the full amount of the MCO provider tax pursuant to the timelines applicable under the approval letter has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medicaid beneficiaries. In addition, the commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan did not have the information necessary from the department to pay the tax required in this section. Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make MCO provider tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medicaid beneficiaries.

(c) Overpayment by or on behalf of a health plan of a payment shall be applied to any other payment due from the health plan pursuant to this section, or, if no payment is due, at the election of the health plan, shall be applied to future payments or refunded to the health plan. Interest shall be paid on overpayments from the date of overpayment to

the date of crediting or refunding at the rate determined in accordance with this subdivision only if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

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

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

§ 2807-i. Service and quality improvement grants. 1. Grants to facilitate cooperative ventures for sharing administrative, management and operational services. a. Notwithstanding any inconsistent provision of law to the contrary, within amounts available therefor, the commissioner shall make grants pursuant to this subdivision to eligible applicants to facilitate cooperative ventures for sharing administrative, management and operational services among general hospitals and other health care providers. Funded projects shall include two or more hospitals and may also include other health care providers in coordination with those hospitals. Funded projects shall be designed to demonstrate the extent to which such cooperative arrangements would result in a reduction in costs to the facilities involved.

b. In order to be eligible to receive a grant under this subdivision, applicants shall prepare and submit to the commissioner a proposal at such time, in such manner and containing such information as the commissioner may require, including:

(i) a statement that such providers desire to negotiate and enter into a voluntary agreement;

(ii) a description of the nature and scope of the activities contemplated in the cooperative agreement;

(iii) a description of the financial arrangement between the providers that are parties to the agreement;

(iv) a description of the geographic area generally served by the providers;

(v) a description of the anticipated benefits and advantages to providers and to health care consumers;

(vi) a description of how the proposal will be coordinated with the regional health plan; and

(vii) any other information determined appropriate by the commissioner.

c. In awarding grants under this subdivision, the commissioner shall assure that there is a sufficiently representative geographic and size distribution of grantees, including urban, rural and suburban grantees.

d. Amounts provided under a grant awarded under this subdivision shall only be used for the planning of cooperative ventures and shared services.

e. Grantees shall submit reports to the commissioner in such form and at such times as the commissioner may by regulation require, for the purpose of evaluating the operations and results of such program.

f. The commissioner in evaluating proposals pursuant to this section shall give primary consideration to the financial condition of applicants; provided however, that an applicant's financial condition shall not be the sole grounds for approval or rejection.

2. Management information systems grants. Notwithstanding any inconsistent provision of law to the contrary, within amounts available therefor, the commissioner shall make grants pursuant to this subdivision to general hospitals, not to exceed two hundred thousand dollars per hospital, for the purposes of expanding and improving their information management capabilities. In order to be eligible for grants pursuant to this subdivision, general hospitals which have experienced operating losses for the past two consecutive years, provided such operating losses have been at least two percent of such hospital's operating expenses, shall submit proposals which demonstrate that:

a. hospital management, productivity, and operations would be enhanced by improvements to the hospital's current management information system capabilities;

b. the cost of providing services would be contained or patient access to care or the quality of patient care would be improved;

c. such hospital's clinical, management and finance information systems would be integrated; and

d. cost finding and cost accounting capabilities would be enhanced.

3. Continuous quality improvement grants. Grants shall be awarded to

general hospitals, within amounts available therefor, to establish programs to improve quality assurance activities. Such programs shall seek to promote and encourage continuous quality improvement by integrating traditional medical staff review functions with risk management and infection control activities. Grants shall be used to support the following:

a. the establishment of a mission statement, an accompanying long term strategic plan and allocation of institutional resources which reflect the institution's commitment to continuous quality improvement;

b. the establishment of quality improvement activities which will enhance all institutional processes, including clinical, managerial and support functions;

c. activities which support a multidisciplinary collaborative approach to quality improvement;

d. integration of management information systems to improve health care delivery; and

e. an educational program on continuous quality improvement to inform staff of the institution's mission and plan for quality.

4. Equitable distribution. Funding shall as far as practicable be equitably distributed among applicants in urban, suburban and rural areas of the state.

*** § 2807-j. Patient services payments.** 1. Payments to designated providers of services, as defined in paragraph (a) of subdivision one-a of this section, by all payors, including the state governmental agencies, corporations organized and operating in accordance with article forty-three of the insurance law, organizations operating in accordance with the provisions of article forty-four of this chapter, local governmental agencies, self-insured funds, commercial insurers, payors pursuant to the comprehensive motor vehicle insurance reparations

act, the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, and any other rate, charge, or negotiated payment payor, for patient services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) shall include a surcharge for an allowance on net patient service revenues in the percentage amount and for the periods specified in subdivision two of this section. Any such allowance shall be submitted by or on behalf of designated providers of services to the commissioner or the commissioner's designee in accordance with subdivision five of this section.

1-a. Definitions. (a) "Designated providers of services", for purposes of this section, shall mean providers of services in the following classes:

- (i) general hospitals;

- (ii) diagnostic and treatment centers that provide:

- (A) a comprehensive range of primary health care services; or

- (B) ambulatory surgical services; and

- (iii) for periods prior to October first, two thousand, subject to the provisions of paragraph (d) of subdivision three of this section, free-standing clinical laboratories issued a permit pursuant to title five of article five of this chapter.

(b) "Third-party coverage", for purposes of this section, shall include, but not be limited to: payments by a governmental agency, insurer, health maintenance organization, self-insured fund, or other third-party entity making payments on behalf of a patient; whether made directly to a designated provider of services or indirectly as indemnity or similar payments made to the patient (or patient's representative such as parent or family member) for services provided by a designated provider of services, or through the use of payments made payable to both the designated provider of services and the patient or patient's representative, or similar devices.

(c) "Third-party payors", for purposes of this section, shall include, but not be limited to: governmental agencies; corporations organized and operating in accordance with article forty-three of the insurance law; organizations operating in accordance with the provisions of article

forty-four of this chapter; providers of coverage pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, and the volunteer ambulance workers' benefit law; self-insured funds and administrators acting on behalf of self-insured funds; and commercial insurers licensed to do business in this state and authorized to write accident and health insurance and whose policy provides coverage on an expense incurred basis.

2. (a) The total percentage allowance for any period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, for a designated provider of services applicable to a payor shall be determined in accordance with this subdivision and applied to net patient service revenues.

(b) The total percentage allowance for each payor, other than governmental agencies, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, and other than payments for a patient that has no third-party coverage in whole or in part for services provided by a designated provider of services, shall be:

(i) the sum of (A) eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be eight and ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the percentage shall be nine and sixty-three hundredths percent, plus (B) twenty-four percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be twenty-five and ninety-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be twenty-six and twenty-six hundredths percent, and further

provided that for services provided on and after April first, two thousand nine, the percentage shall be twenty-eight and twenty-seven hundredths percent, and plus (C) for a specified third-party payor as defined in subdivision one-a of section twenty-eight hundred seven-s of this article the percentage allowance applicable for a general hospital for inpatient hospital services pursuant to subdivision two of section twenty-eight hundred seven-s of this article;

(ii) unless (A) an election in accordance with paragraph (a) of subdivision five of this section to pay the allowance directly to the commissioner or the commissioner's designee is in effect for a third-party payor, and in addition (B) for a specified third-party payor an election to pay the assessment in accordance with section twenty-eight hundred seven-t of this article is in effect.

(c) If an election in accordance with subdivision five of this section is in effect for a third-party payor and in addition in accordance with section twenty-eight hundred seven-t of this article for a specified third-party payor, the total percentage allowance factor shall be reduced to eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance factor shall be reduced to eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance factor shall be reduced to eight and ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance factor shall be reduced to nine and sixty-three hundredths percent.

(d) The total percentage allowance for payments by governmental agencies, as determined in accordance with paragraphs (a) and (a-1) of subdivision one of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, shall be five and ninety-eight-hundredths percent, provided, however, that for services provided on and after July first, two thousand three

the total percentage allowance shall be six and forty-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be six and fifty-four hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance shall be seven and four hundredths percent.

(e) The total percentage allowance for payments for services provided by designated providers of services for which there is no third-party coverage in whole or in part shall be eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be eight and ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance shall be nine and sixty-three hundredths percent. This paragraph shall not apply to patient deductibles and coinsurance amounts.

(f) The total percentage allowance for patient deductibles and coinsurance amounts shall be the same percentage allowance applicable to payments by the primary third-party payor covering the patient in each case determined in accordance with paragraphs (a), (b) and (c) of this subdivision.

(g) The total percentage allowance for secondary third-party payors under coordination of benefits principles shall be the same percentage allowance applicable to payments by the primary third-party payor in the case determined in accordance with paragraphs (a), (b) and (c) of this subdivision.

3. Net patient service revenues, for purposes of this section, shall mean:

(a) for general hospitals all moneys received for or on account of inpatient hospital services, outpatient services (including referred ambulatory services), emergency services, ambulatory surgical services, and other hospital or health-related services, including capitation payments allocable to inpatient hospital services, outpatient services (including referred ambulatory services), emergency services, ambulatory

surgical services and other hospital or health-related services excluding services listed below, less refunds, for discharges occurring or for visits made or services performed on or after January first, nineteen hundred ninety-seven, or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven excluding the following subject to the provisions of subdivision eleven of this section:

(i) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(ii) revenue received by a general hospital for residential health care facility services, adult day care services, hospice services, and home care services;

(iii) revenue received from the allowances pursuant to this section and section twenty-eight hundred seven-s of this article;

(iv) revenue received from bad debt and charity care and indigent care rate adjustments and pool distributions pursuant to section twenty-eight hundred seven-c of this article, general hospital indigent care pool distributions pursuant to section twenty-eight hundred seven-k of this article, health care services pool distributions pursuant to section twenty-eight hundred seven-c of this article, health care initiatives pool distributions pursuant to section twenty-eight hundred seven-l of this article, professional education pool distributions pursuant to section twenty-eight hundred seven-m of this article, tobacco control and insurance initiatives pool distributions pursuant to section twenty-eight hundred seven-v of this article, and high need indigent care adjustment pool distributions pursuant to section twenty-eight hundred seven-w of this article, provided, however, that funds received as medical assistance payments which include state share amounts authorized pursuant to section twenty-eight hundred seven-v of this article that are not disproportionate share hospital payments shall be included within the meaning of net patient service revenue for the purposes of this section;

(v) revenue received from physician practice or faculty practice plan discrete billings for physician services;

(vi) revenue received by a general hospital from a public hospital pursuant to an affiliation agreement contract for the delivery of health care services to such public hospital;

(vii) revenue received from governmental deficit financing;

(viii) subject to the provisions of paragraph (d) of this subdivision, revenue received for or on account of referred ambulatory clinical laboratory visits made or services performed on and after October first, two thousand.

(b) for diagnostic and treatment centers providing services designated in subparagraph (ii) of paragraph (a) of subdivision one-a of this section all moneys received, including capitation payments allocable to diagnostic and treatment center services otherwise covered by the assessment, less refunds, for or on account of visits made or services performed on or after January first, nineteen hundred ninety-seven or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven:

(i) for the following services:

(A) for diagnostic and treatment centers providing a comprehensive range of primary health care services, for all services;

(B) for diagnostic and treatment centers providing ambulatory surgical services, for all ambulatory surgical services;

(ii) excluding the following subject to the provisions of subdivision eleven of this section:

(A) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(B) revenue received from the allowances pursuant to this section;

(C) revenue received from bad debt and charity care rate adjustments pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article, health care services pool distributions pursuant to section twenty-eight hundred seven-c of this article, health care initiatives pool distributions pursuant to section twenty-eight hundred seven-l of this article, professional education pool distributions pursuant to section twenty-eight hundred seven-m of this article, tobacco control and insurance initiatives pool distributions pursuant to section twenty-eight hundred seven-v of this article, and high need indigent care adjustment pool distributions pursuant to section twenty-eight hundred seven-w of this article;

(D) revenue received from physician practice or faculty practice plan discrete billings for physician services;

(E) for a diagnostic and treatment center operated by a health

maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law, revenue received for or on account of services provided to subscribers of such health maintenance organization;

(F) revenue received from governmental deficit financing; and

(G) subject to the provisions of paragraph (d) of this subdivision, revenue received for or on account of referred clinical laboratory visits made or services performed on and after October first, two thousand.

(c) for free-standing clinical laboratories, all moneys received, including capitation payments, less refunds, for or on account of visits made or services performed on or after January first, nineteen hundred ninety-seven and prior to October first, two thousand, subject to the provisions of paragraph (d) of this subdivision, or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven and prior to October first, two thousand, subject to the provisions of paragraph (d) of this subdivision, for clinical laboratory services, excluding, subject to the provisions of subdivision eleven of this section:

(i) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(ii) revenue received from the allowances pursuant to this section;

(iii) for a clinical laboratory operated by a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law, revenue received for or on account of services provided to subscribers of such health maintenance organization; and

(iv) revenue received from governmental deficit financing.

(d) Provided, however, that if either the provisions of clause (G) of subparagraph (ii) of paragraph (b) of this subdivision or subparagraph (viii) of paragraph (a) of this subdivision which exclude certain revenues from the definition of net patient service revenues for the purpose of imposing surcharges pursuant to this section, result in a determination of an impermissible provider tax by the secretary of the U.S. department of health and human services under the provisions of section 1903(w) of the federal social security act, then clause (G) of subparagraph (ii) of paragraph (b) of this subdivision, subparagraph

(viii) of paragraph (a) of this subdivision, and sections forty-eight and forty-nine of chapter one of the laws of nineteen hundred ninety-nine are rendered null and void as of October first, two thousand. The commissioner will collect any retroactive amounts due as a result of surcharges imposed on such services on and after October first, two thousand, without interest or penalty.

4. (a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the allowances established pursuant to this section, and funds from the assessments established pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two million two hundred thousand dollars for collection and distribution of allowances and assessments established pursuant to this section and subdivision eighteen of section twenty-eight hundred seven-c of this article, shall be paid from the allowance and assessment funds.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of bad debt and charity care pools for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to section twenty-eight hundred seven-c of this article may be extended to provide for administration pursuant to this section and distributions of allowance and assessment funds pursuant to this article and may be amended as may be necessary.

(c) The commissioner shall contract with an independent certified public accountant to conduct an annual independent audit, in conformance with generally accepted auditing standards, of the receipts, disbursements, revenues, expenditures and cash flows of funds, for each

calendar year beginning with nineteen hundred eighty-three, through the most recent calendar year. As used in this section, "funds" shall mean:

(i) Funds accumulated and pooled pursuant to this section, paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article; and

(ii) Funds accumulated and pooled pursuant to chapters five hundred thirty-six, five hundred thirty-seven and five hundred thirty-eight of the laws of nineteen hundred eighty-two, chapters eight hundred seven and nine hundred six of the laws of nineteen hundred eighty-five, chapters two and six hundred five of the laws of nineteen hundred eighty-eight, chapters nine hundred twenty-two and nine hundred twenty-three of the laws of nineteen hundred ninety, chapter seven hundred thirty-one of the laws of nineteen hundred ninety-three and chapter eighty-one of the laws of nineteen hundred ninety-five.

Such annual independent audit shall be submitted to the director of the budget, the temporary president of the senate and the speaker of the assembly no later than April fifteenth of each year.

5. (a) Any third-party payor for services provided by a designated provider of services may make an election to make payments on an aggregated basis of funds due from the allowance determined pursuant to subdivision two of this section directly to the commissioner or the commissioner's designee on behalf of designated providers of services.

(i) The election pursuant to this paragraph to be effective must be in writing, filed with the commissioner or the commissioner's designee on such forms and in such manner as the commissioner shall require. An election must apply to all classes of designated providers of service and to all providers within each class. An election by a payor shall take effect for nineteen hundred ninety-seven, on the next following January first, April first, July first, or October first, and for each calendar year thereafter on the next following January first, not less than thirty days after the election is filed. Beginning December first, nineteen hundred ninety-seven, an election pursuant to this paragraph must be made no later than December first of the year prior to the assessment year. However, any payor licensed pursuant to the insurance

law or certified pursuant to article forty-four of this chapter between December first of the year prior to the assessment year and December thirty-first of the assessment year may make an election subsequent to such licensure, and during said time period, to take effect on the next following January first, April first, July first or October first not less than thirty days after such election is filed. Payors other than those licensed pursuant to the insurance law or certified pursuant to this chapter which have not provided third-party coverage prior to December first of the year prior to the assessment year may make an election at any time from December first of the year prior to said assessment year to December thirty-first of the assessment year, to take effect on the next following January first, April first, July first or October first not less than thirty days after the election is filed. Beginning June first, two thousand three an election by any payor or organization shall begin on the first day of the month following the date it was received by the commissioner.

(ii) An election shall remain in effect unless revoked in writing by a specified third-party payor, which revocation shall be effective on the first day of the next month, provided that such payor has provided notice of its intention to so revoke at least twenty days prior to the beginning of such month.

(iii) A payor filing an election pursuant to this paragraph must agree:

(A) to provide reports in accordance with the provisions of paragraph (b) of subdivision seven of this section;

(B) to provide such certification of data and access to allowance expenditure data for audit verification purposes as the commissioner shall require for purposes of this section; and

(C) to the jurisdiction of the state to maintain an action in the courts of the state of New York to enforce any provision of this section related to payment of the allowances.

(D) for periods on and after January first, two thousand nine, to provide the commissioner or the commissioner's designee the payor's federal tax identification number and agree to the use of such identification number in connection with identifying the payor's election status to designated providers of services, including the posting of such identification numbers on secure websites maintained by

the commissioner or the commissioner's designee in furtherance of the purposes of this section. The commissioner shall include for periods on and after January first, two thousand nine on such secure websites, the date such payor was first posted.

(iv) If a payor is acting in an administrative services capacity on behalf of an organization, such as a self-insured fund, the consent of the organization to the election and the conditions pursuant to subparagraph (iii) of this paragraph must be submitted with the election. Such consent may be set forth in writing in the agreement between the payor and the organization and a photocopy of that portion of the agreement submitted by the payor, together with a photocopy of the signatures of the organization and the payor on the agreement, shall be accepted in lieu of a separate election form from the organization. On and after January first, two thousand four, the commissioner shall have discretion to accept payments made on a timely basis if the reports and information reports are routinely submitted, notwithstanding the fact that the full and complete election form by or on behalf of an organization was not filed on a timely basis. In the event the commissioner accepts payments pursuant to this section where an election form is missing or incomplete but the payments and information reports were routinely submitted as if the election forms had been filed, the election form from the payor and organization shall be deemed to have been filed (and the organization and the payor shall be as legally bound by the terms of the election form as if it had signed and filed the election) and neither the payor nor the organization shall subsequently refuse to abide by the terms of the election form for any year in which payments were submitted and accepted pursuant to this section.

(v) If a payor, including a payor operating in accordance with the insurance law or article forty-four of this chapter, making an election pursuant to this paragraph is acting in an administrative services capacity on behalf of an organization or organizations, such payor must specify whether such election applies to payments on behalf of all such organizations and establish, in accordance with guidelines established by the superintendent of financial services, a system through which designated providers of services and the commissioner can identify the status of a patient as a patient for whom the election does not apply.

(b) The commissioner may deny a payor the opportunity to remit

directly to the commissioner or the commissioner's designee based on repeated late payments, failure to remit correct amounts, or failure to provide adequate verification of the accuracy of payments. The percentage allowance for any such payor shall be the percentage determined in accordance with paragraph (b) of subdivision two of this section.

(c) The commissioner or the commissioner's designee shall make available to all designated providers of services a list of the payors which have elected pursuant to this paragraph to remit payments directly.

5-a. (a) Payments by or on behalf of designated providers of services to the commissioner or the commissioner's designee of funds due from the allowances pursuant to subdivision two of this section or pursuant to payment obligations incurred pursuant to section twenty-eight hundred seven-s of this article or section twenty-eight hundred seven-t of this article shall be made on a monthly basis, provided, however, that for reporting periods relating to payments for services provided or dates of inpatient discharge or contracted service obligations occurring on or after January first, two thousand one, the commissioner may permit certain third-party payors which have at least one full year of pool payment experience to submit such payments on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article are not expected to exceed ten thousand dollars for annual periods prior to January first, two thousand four, and twenty-five thousand dollars for annual periods on and after January first, two thousand four. Payments due by designated providers of services on account of payors in accordance with paragraph (b) of subdivision two of this section shall be two percentage points less than the percentage specified in such paragraph. The designated provider of services shall retain for compensation for such provider's administrative responsibilities the amount that represents the difference. Payments due by designated providers of services on account of all other payors shall be calculated on the basis of the percentage allowance applicable to such payor pursuant to paragraphs (d), (e), (f) and (g) of subdivision

two of this section. Payments shall be due on or before the thirtieth day following the end of a calendar month to which an allowance applies.

(b) Notwithstanding any inconsistent provision of this section, as shall be necessary to obtain federal financial participation in medical assistance expenditures in accordance with title XIX of the federal social security act, the allowances included in rates of payment pursuant to this section on behalf of patients eligible for medical assistance pursuant to title eleven of article five of the social services law shall be withheld from medical assistance payments to designated providers of services and paid to pools on behalf of the designated provider of services where a designated provider of services elects such withholding in such time and manner as specified by the commissioner, and in the event a designated provider of services does not elect such withholding, payments by such designated provider of services to a pool based on an allowance received for medical assistance patients shall be due within five days of receipt of such funds. Funds withheld by a payor and paid to a pool on behalf of a designated provider of services shall be considered received by such designated provider of services and paid to the pool by such designated provider of services for all purposes.

6. (a) If a payment made by a designated provider of services for a month to which an allowance applies is less than seventy percent of the amount due or which the commissioner estimates is due, based on available financial and statistical data, the commissioner may collect the deficiency pursuant to paragraph (c) of this subdivision.

(b) If a payment made by a designated provider of services for a month to which an allowance applies is less than ninety percent of the amount due or which the commissioner estimates is due, based on available financial and statistical data, and at least two previous payments within the preceding six months were less than ninety percent of the amount due, based on similar evidence, the commissioner may collect the deficiency pursuant to paragraph (c) of this subdivision.

(c) Upon receipt of notification from the commissioner of a designated provider of services' deficiency under this section, the comptroller or a fiscal intermediary designated by the director of the budget, or the commissioner of the office of temporary and disability assistance, or a

corporation organized and operating in accordance with article forty-three of the insurance law, or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or by such article forty-three corporation or article forty-four organization to the designated provider of services the amount of the deficiency determined under paragraph (a), (b) or (e) of this subdivision or paragraph (d) of subdivision eight-a of this section. Upon withholding such amount, the comptroller or a designated fiscal intermediary, or the commissioner of the office of temporary and disability assistance, or corporation organized and operating in accordance with article forty-three of the insurance law or organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or the commissioner's designee, such amount withheld on behalf of the designated provider of services. Such amount shall represent, in whole or in part, the amounts due from the designated provider of services.

(d) The commissioner shall provide a designated provider of services with notice of any estimate of an amount due for an allowance pursuant to paragraph (a) or (b) of this subdivision or paragraph (d) of subdivision eight-a of this section at least three days prior to collection of such amount by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(e) In the event a designated provider of services objects to an estimate by the commissioner pursuant to paragraph (a) or (b) of this subdivision or paragraph (d) of subdivision eight-a of this section of the amount due for an allowance, the designated provider of services, within sixty days of notice of an amount due, may request a public hearing. If a hearing is requested, the commissioner shall provide the designated provider of services an opportunity to be heard and to present evidence bearing on the amount due for an allowance within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. An administrative hearing is not a prerequisite to seeking judicial relief.

(f) The commissioner may direct that a hearing be held without any request by a designated provider of services.

(g) In the event a hearing pursuant to paragraph (e) of this subdivision is not requested and the delinquent amounts in question have

been referred for recoupment or offset pursuant to paragraph (c) of this subdivision, or have been referred to the office of the attorney general for collection, the amount of such delinquencies shall be deemed final and not subject to further revision or reconciliation by the commissioner based on any additional reports or other information submitted by the designated provider of services, provided, however, that such delinquencies shall not be referred for such recoupment or for such collection based on estimated amounts unless the hospital has received written notification of such delinquencies and has been given no less than thirty days in which to submit delinquent reports.

7. (a) (i) Every designated provider of services shall submit reports of net patient service revenues received for or on account of patient services for each month which shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section. For periods on and after January first, two thousand five, reports by designated providers of services shall be submitted electronically in a form as may be required by the commissioner; provided, however, any designated provider of services is not prohibited from submitting reports electronically on a voluntary basis prior to such date, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall be verified with an electronic signature as prescribed by the commissioner.

(ii) For periods on and after January first, two thousand nine, every designated provider of services shall provide the commissioner or commissioner's designee with its federal tax identification number and such identification number shall be used in connection with identifying such providers for purposes pursuant to this section, including the posting of such identification numbers on secure websites maintained by the commissioner or the commissioner's designee in furtherance of the purposes of this section. The commissioner shall include for periods on and after January first, two thousand nine on such secure websites, the date such designated provider of services was first posted. In addition, the commissioner shall, as a part of a final resolution of an audit conducted pursuant to subdivision eight-a of this section, waive payment of interest and penalties otherwise applicable pursuant to subdivision

eight of this section, when the audit findings conclusively indicate that the liability for such interest and penalties are the result of a delay in the listing of a new designated provider of services on the secure website maintained by the department.

(b) (i) Every third-party payor making an election in accordance with paragraph (a) of subdivision five of this section shall submit reports of patient service expenditures for services provided by designated providers of services for each month which shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section, provided, however, that for reporting periods relating to payments for services provided or dates of inpatient discharge or contracted service obligations occurring on or after January first, two thousand one, the commissioner may permit certain third-party payors which have at least one full year of pool payment experience to submit such reports on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article are not expected to exceed ten thousand dollars for annual periods prior to January first, two thousand four, and twenty-five thousand dollars for annual periods on and after January first, two thousand four.

(ii) For periods on and after July first, two thousand four, reports submitted on a monthly basis by third-party payors in accordance with subparagraph (i) of this paragraph and reports submitted on a monthly or annual basis by payors acting in an administrative services capacity on behalf of electing third-party payors in accordance with subparagraph (i) of this paragraph shall be made electronically in a form as may be required by the commissioner; provided, however, any third-party payor, except payors acting in an administrative services capacity on behalf of electing third-party payors, which, on or after January first, two thousand four, elects to make payments directly to the commissioner or the commissioner's designee pursuant to subdivision five of this section, shall be subject to this subparagraph only after one full year of pool payment experience which results in reports being submitted on a monthly basis, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall

be verified with an electronic signature as prescribed by the commissioner. This subparagraph shall not be interpreted to prohibit any third-party payor from submitting reports electronically on a voluntary basis.

(c) If a designated provider of services or a third-party payor fails to file reports required pursuant to paragraph (a) or (b) of this subdivision and which are due on and after January first, two thousand, within sixty days of the date such reports are due and after notification of such reporting delinquency, the commissioner may assess a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the payor or provider demonstrates good cause for the failure to timely file such reports. Such penalties shall be subject to the provisions of section twelve-a of this chapter.

8. (a) If a payment made pursuant to this section or to section twenty-eight hundred seven-s or twenty-eight hundred seven-t of this article for a month to which an allowance applies is less than ninety percent of the amount due or which the commissioner estimates, based on available financial and statistical data, is due for such month, interest shall be due and payable to the commissioner by a designated provider of services, or by a third-party payor, other than a state governmental agency, that has elected to pay an allowance directly, on the difference between the amount paid and the amount due or estimated to be due from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or, if greater, at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest due from a designated provider of services, if not paid by the due date of the following month's payment, may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an allowance pursuant to subdivision two of this section.

(b) If a payment made for a month to which an allowance applies is less than seventy percent of the amount due or which the commissioner

estimates, based on available financial and statistical data, is due for such month, a penalty shall be due and payable to the commissioner by a designated provider of services, or by a third-party payor, other than a state governmental agency, that has elected to pay an allowance directly, of five percent of the difference between the amount paid and the amount due or estimated to be due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty due from a designated provider of services may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an allowance pursuant to subdivision two of this section.

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

8-a. (a) Payments and reports submitted or required to be submitted to the commissioner or to the commissioner's designee pursuant to this section and section twenty-eight hundred seven-s of this article by designated providers of services and by third-party payors which have elected to make payments directly to the commissioner or to the commissioner's designee in accordance with subdivision five-a of this section, shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by designated providers of services or by third-party payors with regard to subsequent

payments, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year period, or from conducting an audit of any adjustment or reconciliation made by a designated provider of services or by a third party payor which has elected to make such payments directly to the commissioner or the commissioner's designee, or from conducting an audit of payments made prior to such six year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section.

(b) Designated providers of services or third-party payors which, in the course of an audit pursuant to this section or section twenty-eight hundred seven-s of this article, fail to produce data or documentation requested in furtherance of such an audit, within thirty days of such request, may be assessed a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the audited entity demonstrates good cause for such failure. The imposition of civil penalties pursuant to this section shall be subject to the provisions of section twelve-a of this chapter.

(c) Records required to be retained for audit verification purposes by designated providers of services and third-party payors in accordance with this section and section twenty-eight hundred seven-s of this article shall include, but not be limited to, on a monthly basis, the source records generated by supporting information systems, detailed claims information, detailed patient revenue information, capitation arrangements, financial accounting records, relevant correspondence and such other records as may be required to prove compliance with, and to support the reports submitted in accordance with, this section and section twenty-eight hundred seven-s of this article.

(d) If a designated provider of services or a third party payor fails to produce data or documentation requested in furtherance of an audit pursuant to this section or pursuant to section twenty-eight hundred seven-s of this article, for a month to which an allowance applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of the patient services revenue exemptions specified

pursuant to this section, or pursuant to section twenty-eight hundred seven-s of this article, cannot be determined from such available financial and statistical data, the amount due may be calculated on the basis of the aggregate total of patient services revenue derived from such data for the year subject to audit. The commissioner shall take all necessary steps to collect amounts due as determined pursuant to this paragraph, including directing the state comptroller to offset such amounts due from any payments made by the state pursuant to this article to a designated provider of services or a third party payor. Interest and penalties shall be applied to such amounts due in accordance with the provisions of subdivision eight of this section.

(e) The commissioner may, as part of a final resolution of an audit conducted pursuant to this subdivision, waive payment of interest and penalties otherwise applicable pursuant to subdivision eight of this section when amounts due as a result of such audit, other than such waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of the issuance of a final audit report that is mutually agreed to by the commissioner and auditee, provided, however, that if such final audit report is not so mutually agreed upon, then neither the commissioner nor the auditee shall have any obligations pursuant to this paragraph.

(f) The commissioner may enter into agreements with designated providers of services, and with third-party payors, in regard to which audit findings or prior settlements have been made pursuant to this section or section twenty-eight hundred seven-s of this article, extending and applying such audit findings or prior settlements, or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable to such subsequent unaudited periods when such amounts due as a result of such agreement, other than reduced or waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this section and section twenty-eight hundred seven-s of this article, as referenced in such

agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by providers and payors subsequent to such agreements.

9. Funds accumulated, including income from invested funds, from the allowances specified in this section, and the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, and the assessments pursuant to paragraph (c) of subdivision nine of section twenty-eight hundred seven-d of this article, plus such funds as may be allocated in accordance with section twenty-eight hundred seven-s of this article, including interest and penalties, shall be deposited by the commissioner or the commissioner's designee as follows:

(a) funds shall be deposited and credited to a special revenue-other fund to be established by the comptroller or to the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable. To the extent of funds appropriated therefore, the commissioner shall make payments to general hospitals related to bad debt and charity care pursuant to section twenty-eight hundred seven-k of this article. Funds shall be deposited in the following amounts:

(i) fifty-seven and thirty-three-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) fifty-seven and one-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) fifty-five and thirty-two-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand twenty-eight, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand twenty-nine through March thirty-first, two thousand twenty-nine.

(b) funds shall be accumulated in a health care initiatives pool established by the commissioner, for distribution in accordance with section twenty-eight hundred seven-l of this article, in the following amounts:

(i) forty-two and sixty-seven-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) forty-two and ninety-nine-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) forty-four and sixty-eight-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and

(iv) the remaining balance of the funds accumulated for each period on and after January first, two thousand.

10. Notwithstanding any inconsistent provision of law or regulation to the contrary, the allowances applicable to payments by state governmental agencies pursuant to subdivision two of this section shall be reflected in the determination of reimbursement rates pursuant to sections twenty-eight hundred seven and twenty-eight hundred seven-c of this article and fees for clinical laboratory services under the medical assistance program.

11. Each exclusion from the allowances effective on or after January first, nineteen hundred ninety-seven established pursuant to this section shall be contingent upon either: (a) qualification of the allowances for waiver pursuant to federal law and regulation; or (b) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the allowances under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the allowances not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the allowances relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the

event the secretary of the department of health and human services determines that the allowances do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of January first, nineteen hundred ninety-seven, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the designated provider of services or third-party payor that has elected to pay directly pays the retroactive amount due within ninety days of notice from the commissioner to the designated provider of services or third-party payor that has elected to pay directly that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner or the commissioner's designee to the designated provider of services or third-party payor that has elected to pay directly.

12. Revenue from the allowances pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

* NB Expires December 31, 2029

§ 2807-k. General hospital indigent care pool. 1. Definitions. For purposes of this section, the following words or phrases shall have the following meanings, unless the context otherwise requires:

(a) "Major public general hospital" means all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(b) "Nominal payment amount" shall mean the sum of the dollars

attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to a scale.

(c) "Targeted need" shall mean the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the commissioner to general hospital inpatient and ambulatory services, excluding referred ambulatory services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period. Base year data and statistics for the calendar year two years prior to the distribution period shall be considered final, for purposes of this section, one hundred twenty days after hospitals receive the department's initial statewide rates for the same period as the distribution period and shall include any appropriate revisions reported by hospitals during such one hundred twenty days.

(d) "Uncompensated care need" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

(e) "Uninsured care" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payments made directly to the general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The cost of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

(f) "Ambulatory services" of a general hospital shall mean all services delivered on an ambulatory basis, including, for periods on and after January first, two thousand four, services provided at qualified hospital-controlled diagnostic and treatment centers except as otherwise provided in subdivision thirteen of this section.

(g) "Qualified hospital-controlled diagnostic and treatment center"

shall mean a voluntary, non-profit diagnostic and treatment center providing a comprehensive range of primary health care services that is controlling, controlled by, or under common control with a general hospital, and as of June thirtieth, two thousand three:

(i) qualified for an allocation of funds pursuant to section twenty-eight hundred seven-p of this article or pursuant to section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven, as amended; or

(ii) the outpatient department of such general hospital had been designated a federally-qualified health center under section 330 of the Public Health Service Act (42 U.S.C. § 254b) and had directly received a grant under such section.

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

2. To the extent of funds appropriated therefor, funds shall be made available for distribution by or on behalf of the state in accordance with the following methodology, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from a general hospital indigent care pool established by the commissioner.

3. Each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for each year through December thirty-first, two thousand fourteen, an amount equal to the amount allocated to such major public general hospital from the regional pool established pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

4. (a) From funds in the pool for each year, thirty-six million dollars shall be reserved on an annual basis through December thirty-first, two thousand fourteen, for distribution as high need

adjustments in accordance with subdivision six of this section, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

(a-1) From funds in the pool for each year, twenty-seven million dollars shall be reserved on an annual basis for the periods January first, two thousand through December thirty-first, two thousand ten, for distribution in accordance with subdivision sixteen of this section, provided, however, that payments on and after January first, two thousand nine through December thirty-first, two thousand nine shall be subject to the provisions of subdivisions five-a and five-b of this section, and shall be subject to the provisions of subdivision five-b of this section for periods on and after January first, two thousand ten.

(b) The balance of funds in a pool not allocated in accordance with subdivision three of this section or reserved for distributions pursuant to subdivisions six and sixteen of this section shall be distributed to eligible general hospitals, excluding major public general hospitals, on the basis of each general hospital's targeted need share, adjusted for transition factors in accordance with subdivision seven of this section.

(c) To be eligible for distributions from the pool, a general hospital's targeted need must exceed one-half of one percent.

(d) For the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, each eligible general hospital's targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in subdivision five of this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available in the pool.

5. The scale utilized for development of each eligible general hospital's nominal payment amount shall be as follows:

Percentage of Reimbursement

Targeted Need Percentage		Attributable to that Portion of Targeted Need
0	-.5%	60%
.5+	-2%	65%
2+	-3%	70%
3+	-4%	75%
4+	-5%	80%
5+	-6%	85%
6+	-7%	90%
7+	-8%	95%
8+		100%

5-a. Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, subject to the availability of federal financial participation and within amounts appropriated, for periods on and after January first, two thousand nine, ten percent of the aggregate distributions to each general hospital made otherwise pursuant to this section and section twenty-eight hundred seven-w of this article shall be reserved and set aside and distributed in accordance with the following:

(a) Thirteen million nine hundred thirty thousand dollars of such reserved funds shall be distributed to major public hospitals and shall be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with the provisions of paragraph (c) of this subdivision; and

(b) Seventy million seven hundred seventy thousand dollars of such reserved funds shall be distributed to general hospitals other than major public general hospitals and shall be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with the provisions of paragraph (c) of this subdivision; and

(c) For the purposes of distributions in accordance with paragraphs (a) and (b) of this subdivision, each facility's relative uncompensated care need amount shall be determined in accordance with the following:

(i) inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, but excluding

referred ambulatory units of services, shall be multiplied by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January first, two thousand ten, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July first of the prior year;

(ii) outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department services and ambulatory surgery services, but excluding referred ambulatory services units of service, shall be multiplied by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology as set forth in regulations promulgated pursuant to subdivision two-a of section twenty-eight hundred seven of this article, as in effect for the distribution year, provided further, however, that for those services for which APG rates are not available the applicable Medicaid outpatient rate shall be the rate in effect for the calendar year two years prior to the distribution year;

(iii) the uncompensated care need for each facility for periods on and after January first, two thousand ten shall be reduced by the sum of all payment amounts collected from such patients; and

(iv) the total uncompensated care need for each facility subject to this subdivision shall then be adjusted by application of the nominal need scale set forth in subdivision five of this section.

(d)(i) For annual periods commencing on and after January first, two thousand nine, no general hospital may receive disproportionate share payment distributions made in accordance with this section, section twenty-eight hundred seven-w of this article or made in accordance with other provisions of law, that exceed, in aggregate, the costs incurred by such general hospital during such period in furnishing inpatient and outpatient hospital services to Medicaid eligible patients or to patients who have no health insurance or other source of third party coverage, net of all monies received from non-disproportionate share related Medicaid payments and from payments made by such uninsured patients. For purposes of this paragraph, non-Medicaid payments made to a general hospital by the state or by a unit of local government within the state for services provided to indigent patients shall not be

considered to be a source of third party payment.

(ii) Reductions pursuant to this paragraph shall be made in the following sequence:

(A) payments in accordance with subdivision fourteen-f of section twenty-eight hundred seven-c of this article;

(B) payments made to eligible hospitals pursuant to this section and section twenty-eight hundred seven-w of this article.

(iii) Notwithstanding any contrary provision of this section or section twenty-eight hundred seven-w of this article, in the event a payment made pursuant to this section or section twenty-seven hundred seven-w of this article exceeds a hospital's applicable facility specific disproportionate share limit, then fifty percent of the amount in excess of such limit shall be paid to such facility as a grant from state funds available for distribution in accordance with this section and section twenty-eight hundred seven-w of this article, provided, however, that if payments made to an eligible rural hospital pursuant to this subdivision or section twenty-eight hundred seven-w of this article, result in payments in excess of such disproportionate share limits, then up to one hundred forty thousand dollars of such payments shall be made at one hundred percent of the amount in excess of such limits for each eligible rural hospital.

(e) By no later than December first, two thousand ten, the commissioner shall issue a report evaluating the impact of the distributions made pursuant to this subdivision with regard to units of service to uninsured patients provided by each facility, and with regard to the extent of services provided by each facility to patients eligible for financial aid in accordance with each facility's financial aid policies and procedures as mandated by subdivision nine-a of this section. Such report shall also include the use of data on services to the uninsured to model the impact of the distribution methodology set forth in this subdivision against all funding authorized pursuant to this section and section twenty-eight hundred seven-w of this article.

(f) The commissioner shall conduct outreach and educational activities to inform hospitals on matters relating to data collection and reporting requirements related to services provided to the uninsured and patients eligible for financial aid, including definitions to be utilized for identifying uninsured units of service and proper identification of

out-of-pocket collections from uninsured patients.

5-b. Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law and subject to the availability of federal financial participation, for periods on and after May first, two thousand nine, funds as hereinafter described shall be reserved and set aside and distributed in accordance with the following:

(a) For the period May first, two thousand nine through December thirty-first, two thousand nine payments shall be made as follows:

(i) Ninety percent of funds available for the two thousand nine calendar year pursuant to paragraph (a-1) of subdivision four of this section shall be reserved and set aside and distributed as Medicaid disproportionate share (DSH) payments to the same hospitals and in the same proportional amounts as received pursuant to such paragraph (a-1) in two thousand eight;

(ii) Three hundred seven million dollars shall be distributed as Medicaid DSH payments to facilities designated by the department as teaching hospitals as of December thirty-first, two thousand eight in accordance with a schedule of payments to be set forth in regulations promulgated by the commissioner to compensate such facilities for Medicaid and self-pay losses reported in each facility's two thousand seven annual cost report;

(iii) Sixteen million dollars shall be proportionally distributed as Medicaid DSH payments to non-teaching hospitals based upon their proportion of uninsured losses as defined in paragraph (c) of subdivision five-a of this section to such losses of all non-teaching hospitals on a statewide basis;

(iv) Twenty-five million dollars shall be distributed as Medicaid DSH payments to non-major public hospitals having Medicaid discharges of forty percent or greater as established by the commissioner from data reported in each hospital's two thousand seven annual cost report, in accordance with a schedule to be set forth in regulations promulgated by the commissioner, to compensate such facilities for projected Medicaid net losses, as determined by the commissioner, stemming from modifications to Medicaid payments made pursuant to a chapter of the laws of two thousand nine.

(b) For annual periods beginning January first, two thousand ten payments shall be made as follows:

(i) Two hundred sixty-nine million five hundred thousand dollars shall be distributed as Medicaid DSH payments to non-major public teaching hospitals, and such distributions shall be made on a regional basis to cover, within amounts available for each region, each eligible facility's proportional regional share of unmet need for two thousand seven, provided, however, that such regions and regional allocations and the definition of unmet need shall be set forth in regulations promulgated by the commissioner;

(ii) Twenty-five million dollars shall be distributed as Medicaid DSH payments to hospitals eligible for payments made pursuant to subparagraph (iv) of paragraph (a) of this subdivision based upon each facility's proportion of uninsured losses, as defined in paragraph (c) of subdivision five-a of this section, to such losses for all hospitals eligible for such payments;

(iii) Sixteen million dollars shall be distributed in accordance with the provisions of subparagraph (iii) of paragraph (a) of this subdivision;

(iv) Twenty-five million dollars shall be distributed in accordance with the provisions of subparagraph (iv) of paragraph (a) of this subdivision;

5-c. (a) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through December thirty-first, two thousand ten, distributions pursuant to this section and section twenty-eight hundred seven-w of this article, shall reflect an aggregate reduction of sixty-nine million four hundred thousand dollars, based on the proportion of each hospital's indigent care allocations to the total allocations of all hospitals' indigent care allocations prior to application of this reduction, provided, however, that such reductions shall not be applied to distributions to major public hospitals, including major public hospitals operated by public benefit corporations, and also shall not be applied to distributions made pursuant to subparagraph (ii), (iii) or (iv) of paragraph (b) of subdivision five-b of this section.

(b) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period January first, two thousand eleven through December thirty-first, two thousand eleven and each calendar year thereafter, distributions pursuant to this section and section twenty-eight hundred seven-w of this article shall reflect an aggregate reduction of seventy-three million two hundred thousand dollars, based on the proportion of each hospital's indigent care allocation to the total allocations of all hospitals' indigent care allocations prior to application of this reduction, provided, however, that such reductions shall not be applied to distributions to major public hospitals, including major public hospitals operated by public benefit corporations, and shall also not be applied to distributions made pursuant to subparagraph (ii), (iii) or (iv) of paragraph (b) of subdivision five-b of this section.

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand twenty, through December thirty-first, two thousand twenty-nine, all funds available for distribution pursuant to this section, except for funds distributed pursuant to paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such

uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand twenty through two thousand twenty-nine calendar years shall be in accord with the following:

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

(2) for the calendar years two thousand twenty-five and thereafter, the total distributions to major public general hospitals shall be subject to an aggregate reduction of one hundred thirteen million four hundred thousand dollars annually, provided that general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended, shall not receive distributions pursuant to this subdivision; and

(B) nine hundred sixty-nine million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

For the calendar years two thousand twenty through two thousand twenty-two, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of one hundred fifty million dollars annually, provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article shall not be subject to such reduction.

For the calendar years two thousand twenty-three through two thousand twenty-nine, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of two hundred thirty-five million four hundred thousand dollars annually, provided that eligible general hospitals, other than major public general hospitals that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of

this article as of April first, two thousand twenty, shall not be subject to such reduction.

Such reductions shall be determined by a methodology to be established by the commissioner. Such methodologies may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.

(iii) For calendar years two thousand twenty through two thousand twenty-nine, sixty-four million six hundred thousand dollars shall be distributed to eligible general hospitals, other than major public general hospitals, that experience a reduction in indigent care pool payments pursuant to this subdivision, and that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty. Such distribution shall be established pursuant to regulations promulgated by the commissioner and shall be proportional to the reduction experienced by the facility.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

6. Funds reserved for high need adjustments shall be distributed to

general hospitals, excluding major public general hospitals, with nominal need in excess of four percent as follows: each general hospital's share of the reserved amount shall be based on such hospital's aggregate share of nominal need above four percent compared to the total aggregate nominal need above four percent of all eligible hospitals.

7. (a) Hospital specific transition adjustment. Notwithstanding any inconsistent provision of this section, distributions to general hospitals determined in accordance with subdivision four of this section shall be adjusted as follows:

(i) For general hospitals which qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation one hundred percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivisions fourteen-c and seventeen and paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation seventy-five percent of the amount determined in accordance with clause (A) of this subparagraph and twenty-five percent of the amount determined in accordance with subdivision four of this section; and

(C) for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, each such general hospital shall receive as an allocation fifty percent of the amount determined in accordance with clause (A) of this subparagraph and fifty percent of the amount determined in accordance with subdivision four of this section; and

(D) for the period January first, two thousand through December thirty-first, two thousand, each such general hospital shall receive as

an allocation twenty-five percent of the amount determined in accordance with clause (A) of this subparagraph and seventy-five percent of the amount determined in accordance with subdivision four of this section provided, however, that for any general hospital whose distribution is greater when determined solely in accordance with subdivisions four and six of this section than when determined according to this clause, such general hospital's distribution shall not be adjusted pursuant to this clause; and

(E) for periods on and after January first, two thousand one, each such general hospital shall receive as an allocation one hundred percent of the amount determined in accordance with subdivision four of this section.

(ii) For all other general hospitals, excluding major public general hospitals, general hospitals qualifying for an adjustment pursuant to subparagraph (i) of this paragraph, general hospitals which qualified for an adjustment pursuant to subdivision fourteen-d of section twenty-eight hundred seven-c of this article and rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article in nineteen hundred ninety-six:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation fifty percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and fifty percent of the amount determined in accordance with subdivision four of this section; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation twenty-five percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and seventy-five percent of the amount determined in accordance with subdivision four of this section.

(b) Hospital category adjustment. Notwithstanding any inconsistent

provision of this section, distributions to each general hospital, excluding major public general hospitals, for nineteen hundred ninety-seven determined in accordance with subdivision four of this section and paragraph (a) of this subdivision within the categories specified in subparagraph (i) of this paragraph shall be adjusted in accordance with subparagraph (ii) of this paragraph.

(i)(A) General hospitals that qualified for distributions in accordance with subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(B) Rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(C) All other general hospitals, excluding general hospitals that qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article.

(ii) For each category specified in subparagraph (i) of this paragraph, fifty percent of the amount by which the allocation pursuant to subdivision four of this section and paragraph (a) of this subdivision to a general hospital within such category exceeds the projected distribution, as of June first, nineteen hundred ninety-seven, pursuant to subdivision seventeen and, if applicable, subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six to such general hospital shall be reserved by the commissioner for allocation to general hospitals within such category that would experience a loss based on such comparison based on each such general hospital's proportionate share of the aggregate losses for all general hospitals within such category; provided however, that the amount reserved within a category shall not exceed the aggregate amount of losses within such category.

8. Notwithstanding any inconsistent provision of this section, up to five percent of the amount allocated for each of the periods for distributions pursuant to this section may be transferred by the commissioner, to the extent of funds appropriated therefor, and allocated for distributions pursuant to the child health insurance plan established pursuant to title one-A of article twenty-five of this

chapter.

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

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

(b) Such reductions from charges for patients with incomes below at least four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the amount that would have been paid for the same services provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes below at least two hundred percent of the federal poverty level, the hospital shall waive all charges. No nominal payment shall be collected;

(ii) For patients with incomes between at least two hundred percent and up to three hundred percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients

with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases in equal increments as the income of the patient increases, up to a maximum of ten percent of the amount that would have been paid for the same services provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of ten percent of the amount that would have been paid pursuant to such patient's insurance cost sharing;

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

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

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the written notification of patients during the intake and

registration process, and during discharge of the patient, and through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and during discharge of the patient, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the financial assistance policy. The monthly payment under such a plan shall not exceed five percent of the gross monthly income of the patient. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed two percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance at any time during the collection process. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their

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

(f) Such policies and procedures shall provide that patients with incomes below four hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted

as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

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

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

- (iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-1 of this article.

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

(h) Such policies and procedures shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. Such policies and procedures shall prohibit the forced

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

(i) Reports required to be submitted to the department by each general

hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance during the period covered by the report;

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

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

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

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

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

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

(viii) the hospital's financial losses resulting from services provided under medicaid.

(j) Within ninety days of the effective date of this subdivision each

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

(k) Notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

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

10. In order for a general hospital to be eligible for distribution of funds from the pool, such general hospital if it provides obstetrical care and services must be in compliance with the provisions of paragraph (e) of subdivision sixteen of section twenty-eight hundred seven-c of this article.

11. Minimum hospital procedures to determine the availability of insurance or other third-party coverage for hospital services shall be specified by the commissioner.

12. Each general hospital shall submit reports to the department at such time and in such form as the commissioner shall require of:

(a) hospital costs incurred and uncollected amounts in providing services to the uninsured during the period covered by the report; and

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

(c) Such reports shall comply with the reporting requirements established for receipt of bad debt and charity care pool payments as provided in accordance with section twenty-eight hundred seven-c of this article and regulations promulgated thereunder for periods prior to January first, nineteen hundred ninety-seven.

13. Distributions to general hospitals pursuant to this section and the adjustments provided in accordance with subdivision fourteen-f of section twenty-eight hundred seven-c of this article shall be considered disproportionate share payments for inpatient hospital services to general hospitals serving a disproportionate number of low income patients with special needs for purposes of providing assurances to the secretary of health and human services as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act.

14. Notwithstanding any inconsistent provision of law to the contrary, the availability or payment of funds to a general hospital pursuant to this section shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for hospital services provided.

15. Revenue from distributions pursuant to this section and adjustments pursuant to subdivision fourteen-f of section twenty-eight hundred seven-c of this article shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

16. Supplemental indigent care distributions. From available resources established pursuant to paragraph (a-1) of subdivision four of this section, each hospital shall receive a proportionate share, provided that no hospital shall receive less than the reduction amount calculated pursuant to paragraph (d) of subdivision three of section twenty-eight hundred seven-m of this article, subject to hospital specific disproportionate share payment limits calculated in accordance with subdivision twenty-one of section twenty-eight hundred seven-c of this article.

17. Indigent care reductions. For each hospital receiving payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, the commissioner shall reduce the sum of any amounts paid pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article, as computed based on projected facility specific disproportionate share hospital ceilings, by an amount equal to the lower of such sum or each such hospital's payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, provided, however, that any additional aggregate reductions enacted in a chapter of the laws of two thousand ten to the aggregate amounts payable pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article shall be applied subsequent to the adjustments otherwise provided for in this subdivision.

§ 2807-1. Health care initiatives pool distributions. 1. Funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, or the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following.

(a) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to programs to provide health care coverage for

uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter from the respective health care initiatives pools established for the following periods in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to one hundred twenty million six hundred thousand dollars;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, up to one hundred sixty-four million five hundred thousand dollars;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to one hundred eighty-one million dollars;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand, two hundred seven million dollars;

(v) from the pool for the period January first, two thousand one through December thirty-first, two thousand one, two hundred thirty-five million dollars;

(vi) from the pool for the period January first, two thousand two through December thirty-first, two thousand two, three hundred twenty-four million dollars;

(vii) from the pool for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred fifty million three hundred thousand dollars;

(viii) from the pool for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred sixty million nine hundred thousand dollars;

(ix) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to one hundred fifty-three million eight hundred thousand dollars;

(x) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to three hundred twenty-five million four hundred thousand dollars;

(xi) from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred twenty-eight million fifty-nine thousand dollars;

(xii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to four hundred fifty-three million six hundred seventy-four thousand dollars annually;

(xiii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, up to one hundred thirteen million four hundred eighteen thousand dollars;

(xiv) from the health care reform act (HCRA) resources fund for the period April first, two thousand eleven, through March thirty-first, two thousand twelve, up to three hundred twenty-four million seven hundred forty-four thousand dollars;

(xv) from the health care reform act (HCRA) resources fund for the period April first, two thousand twelve, through March thirty-first, two thousand thirteen, up to three hundred forty-six million four hundred forty-four thousand dollars;

(xvi) from the health care reform act (HCRA) resources fund for the period April first, two thousand thirteen, through March thirty-first, two thousand fourteen, up to three hundred seventy million six hundred ninety-five thousand dollars; and

(xvii) from the health care reform act (HCRA) resources fund for each state fiscal year for periods on and after April first, two thousand fourteen, within amounts appropriated.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions for health insurance programs under the individual subsidy programs established pursuant to the expanded health care coverage act of nineteen hundred eighty-eight as amended, and for evaluation of such programs from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following amounts:

(i) (A) an amount not to exceed six million dollars on an annualized

basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine; up to six million dollars for the period January first, two thousand through December thirty-first, two thousand; up to five million dollars for the period January first, two thousand one through December thirty-first, two thousand one; up to four million dollars for the period January first, two thousand two through December thirty-first, two thousand two; up to two million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three; up to one million three hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four; up to six hundred seventy thousand dollars for the period January first, two thousand five through June thirtieth, two thousand five; up to one million three hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven; and up to one million three hundred thousand dollars annually for the period April first, two thousand seven through March thirty-first, two thousand nine, shall be allocated to individual subsidy programs; and

(B) an amount not to exceed seven million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and four million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, and three million dollars for the period January first, two thousand three through December thirty-first, two thousand three, and two million dollars for the period January first, two thousand four through December thirty-first, two thousand four, and two million dollars for the period January first, two thousand five through June thirtieth, two thousand five shall be allocated to the catastrophic health care expense program.

(ii) Notwithstanding any law to the contrary, the characterizations of the New York state small business health insurance partnership program as in effect prior to June thirtieth, two thousand three, voucher program as in effect prior to December thirty-first, two thousand one, individual subsidy program as in effect prior to June thirtieth, two thousand five, and catastrophic health care expense program, as in effect prior to June thirtieth, two thousand five, may, for the purposes

of identifying matching funds for the community health care conversion demonstration project described in a waiver of the provisions of title XIX of the federal social security act granted to the state of New York and dated July fifteenth, nineteen hundred ninety-seven, may continue to be used to characterize the insurance programs in sections four thousand three hundred twenty-one-a, four thousand three hundred twenty-two-a, four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law, which are successor programs to these programs.

(c) Up to seventy-eight million dollars shall be reserved and accumulated from year to year from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, for purposes of public health programs, up to seventy-six million dollars shall be reserved and accumulated from year to year from the pools for the periods January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to eighty-four million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand through December thirty-first, two thousand, up to eighty-five million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand one through December thirty-first, two thousand one, up to eighty-six million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand two through December thirty-first, two thousand two, up to eighty-six million one hundred fifty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand three through December thirty-first, two thousand three, up to fifty-eight million seven hundred eighty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand four through December thirty-first, two thousand four, up to sixty-eight million seven hundred thirty thousand dollars shall be reserved and accumulated from year to year from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to ninety-four

million three hundred fifty thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to seventy million nine hundred thirty-nine thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to fifty-five million six hundred eighty-nine thousand dollars annually shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to thirteen million nine hundred twenty-two thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and for periods on and after April first, two thousand eleven, up to funding amounts specified below and shall be available, including income from invested funds, for:

(i) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, hospital based grants program account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of services and expenses related to general hospital based grant programs, up to twenty-two million dollars annually from the nineteen hundred ninety-seven pool, nineteen hundred ninety-eight pool, nineteen hundred ninety-nine pool, two thousand pool, two thousand one pool and two thousand two pool, respectively, up to twenty-two million dollars from the two thousand three pool, up to ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to eleven million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty-two million ninety-seven thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million five hundred twenty-four thousand

dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to thirteen million four hundred forty-five thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, and up to thirteen million three hundred seventy-five thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen;

(ii) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the emergency medical services training account established in section ninety-seven-q of the state finance law or the health care reform act (HCRA) resources fund, whichever is applicable, up to sixteen million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to twenty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to twenty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to twenty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to twenty-two million five hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million six hundred eighty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million one hundred thirty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-four million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty million four hundred ninety-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million one hundred twenty-three thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to eighteen million three hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to eighteen million nine hundred

fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to nineteen million four hundred nineteen thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, and up to nineteen million six hundred fifty-nine thousand seven hundred dollars each state fiscal year for the period of April first, two thousand fourteen through March thirty-first, two thousand twenty-nine;

(iii) priority distributions by the commissioner up to thirty-two million dollars on an annualized basis for the period January first, two thousand through December thirty-first, two thousand four, up to thirty-eight million dollars on an annualized basis for the period January first, two thousand five through December thirty-first, two thousand six, up to eighteen million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to three million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand twenty-nine to be allocated (A) for the purposes established pursuant to subparagraph (ii) of paragraph (f) of subdivision nineteen of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six and as may thereafter be amended, up to fifteen million dollars annually for the periods January first, two thousand through December thirty-first, two thousand four, up to twenty-one million dollars annually for the period January first, two thousand five through December thirty-first, two thousand six, and up to seven million five hundred thousand dollars for the period January first, two thousand seven through March thirty-first, two thousand seven;

(B) pursuant to a memorandum of understanding entered into by the commissioner, the majority leader of the senate and the speaker of the

assembly, for the purposes outlined in such memorandum upon the recommendation of the majority leader of the senate, up to eight million five hundred thousand dollars annually for the period January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and for the purposes outlined in such memorandum upon the recommendation of the speaker of the assembly, up to eight million five hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven; and

(C) for services and expenses, including grants, related to emergency assistance distributions as designated by the commissioner.

Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other contrary provision of law, such distributions shall be limited to providers or programs where, as determined by the commissioner, emergency assistance is vital to protect the life or safety of patients, to ensure the retention of facility caregivers or other staff, or in instances where health facility operations are jeopardized, or where the public health is jeopardized or other emergency situations exist, up to three million dollars annually for the period April first, two thousand seven through March thirty-first, two thousand eleven, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to two million nine hundred thousand dollars each state fiscal year for

the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine. Upon any distribution of such funds, the commissioner shall immediately notify the chair and ranking minority member of the senate finance committee, the assembly ways and means committee, the senate committee on health, and the assembly committee on health;

(iv) distributions by the commissioner related to poison control centers pursuant to subdivision seven of section twenty-five hundred-d of this chapter, up to five million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to three million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-nine, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four million six hundred thousand dollars annually for the periods January first, two thousand three through December thirty-first, two thousand four, up to five million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to five million one hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand nine, up to three million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to seven hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to two million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to three million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to three million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to three million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to three million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two

thousand twenty-six, and up to three million dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine; and

(v) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, miscellaneous special revenue fund - 339 maternal and child HIV services account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of a special program for HIV services for women and children, including adolescents pursuant to section twenty-five hundred-f-one of this chapter, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to two million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to two million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to five million dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and up to five million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(d) (i) An amount of up to twenty million dollars annually for the period January first, two thousand through December thirty-first, two thousand six, up to ten million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, up to twenty million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to five million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand

fourteen, up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand seventeen through March thirty-first, two thousand twenty, up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, shall be transferred to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article;

(ii) provided, however, amounts transferred pursuant to subparagraph (i) of this paragraph may be reduced in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the health facility restructuring program.

(f) Funds shall be accumulated and transferred from as follows:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, (A) thirty-four million six hundred thousand dollars shall be transferred to funds reserved and accumulated pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article, and (B) eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine,

eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iv) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand through December thirty-first, two thousand four, eighty-two million dollars annually, and for the period January first, two thousand five through December thirty-first, two thousand five, eighty-two million dollars, and for the period January first, two thousand six through December thirty-first, two thousand six, eighty-two million dollars, and for the period January first, two thousand seven through December thirty-first, two thousand seven, eighty-two million dollars, and for the period January first, two thousand eight through December thirty-first, two thousand eight, ninety million seven hundred thousand dollars shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account;

(v) from the health care reform act (HCRA) resources fund for the period January first, two thousand nine through December thirty-first, two thousand nine, one hundred eight million nine hundred seventy-five thousand dollars, and for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-six million one hundred thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, twenty million five hundred thousand dollars, and for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, one hundred forty-six million four hundred thousand dollars, shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit, to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account.

(g) Funds shall be transferred to primary health care services pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with former section twenty-eight hundred seven-bb of this article from the respective health care initiatives pools for the following periods in the following

percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, fifteen and eighty-seven-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, fifteen and eighty-seven-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, sixteen and thirteen-hundredths percent.

(h) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for purposes of primary care education and training pursuant to article nine of this chapter from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision and shall be available for distributions as follows:

(i) funds shall be reserved and accumulated:

(A) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(B) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(C) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(ii) funds shall be available for distributions including income from invested funds as follows:

(A) for purposes of the primary care physician loan repayment program in accordance with section nine hundred three of this chapter, up to five million dollars on an annualized basis;

(B) for purposes of the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter, up to two million dollars on an annualized basis;

(C) for purposes of minority participation in medical education grants in accordance with section nine hundred six of this chapter, up to one million dollars on an annualized basis; and

(D) provided, however, that the commissioner may reallocate any funds remaining or unallocated for distributions for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for distributions in accordance with section twenty-nine hundred fifty-two and section twenty-nine hundred fifty-eight of this chapter for rural health care delivery development and rural health care access development, respectively, from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirteen and forty-nine-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirteen and forty-nine-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirteen and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, seventeen million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to fifteen million eight hundred fifty thousand dollars;

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million eight hundred fifty thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five, up to

nineteen million two hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six, up to nineteen million two hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eighteen million one hundred fifty thousand dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million five hundred thirty-eight thousand dollars, for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to sixteen million two hundred thousand dollars, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions related to health information and health care quality improvement pursuant to former section twenty-eight hundred seven-n of this article from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent.

(k) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for allocations and distributions in accordance with section twenty-eight hundred seven-p of this article for diagnostic and treatment center uncompensated care from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirty-eight and one-tenth percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirty-eight and one-tenth percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirty-eight and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, forty-eight million dollars annually, and for the period January first, two thousand three through June thirtieth, two thousand three, twenty-four million dollars;

(v) (A) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars, for the period January first, two thousand four through December thirty-first, two thousand six, up to twelve million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, up to forty-eight million dollars annually, for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, up to twelve million dollars for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to forty-eight million dollars

annually, for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to forty-eight million dollars annually, for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to forty-eight million dollars annually, for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, up to forty-eight million dollars annually, and for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, up to forty-eight million dollars annually;

(B) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, an additional seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, an additional seven million five hundred thousand dollars annually, for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, an additional one million eight hundred seventy-five thousand dollars, for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, an additional seven million five hundred thousand dollars annually, for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, an additional seven million five hundred thousand dollars annually, for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, an additional seven million five hundred thousand dollars annually, for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, an additional seven million five hundred thousand dollars annually, and for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, an additional seven million five hundred thousand dollars annually for voluntary non-profit diagnostic and treatment center uncompensated care in accordance with subdivision four-c of section twenty-eight hundred seven-p of this article; and

(vi) funds reserved and accumulated pursuant to this paragraph for periods on and after July first, two thousand three, shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer

fund, medical assistance account, for purposes of funding the state share of rate adjustments made pursuant to section twenty-eight hundred seven-p of this article, provided, however, that in the event federal financial participation is not available for rate adjustments made pursuant to paragraph (b) of subdivision one of section twenty-eight hundred seven-p of this article, funds shall be distributed pursuant to paragraph (a) of subdivision one of section twenty-eight hundred seven-p of this article from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable.

(l) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for transfer to and allocation for services and expenses for the payment of benefits to recipients of drugs under the AIDS drug assistance program (ADAP) - HIV uninsured care program as administered by Health Research Incorporated from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, nine and fifty-two-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, nine and fifty-two-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, nine and sixty-eight-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, up to twelve million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to forty million dollars; and

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the periods January first, two thousand

four through December thirty-first, two thousand four, up to fifty-six million dollars, for the period January first, two thousand five through December thirty-first, two thousand six, up to sixty million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to sixty million dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fifteen million dollars, each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to forty-two million three hundred thousand dollars and up to forty-one million fifty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand twenty-nine.

(m) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions pursuant to section twenty-eight hundred seven-r of this article for cancer related services from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, seven and ninety-four-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, seven and ninety-four-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand two, up to ten million dollars on an annual basis;

(v) from the pool for the period January first, two thousand three through December thirty-first, two thousand four, up to eight million nine hundred fifty thousand dollars on an annual basis;

(vi) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand six, up to ten million fifty thousand dollars on an annual basis, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to nineteen million dollars annually, and for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million seven hundred fifty thousand dollars.

(n) Funds shall be accumulated and transferred from the health care reform act (HCRA) resources fund as follows: for the period April first, two thousand seven through March thirty-first, two thousand eight, and on an annual basis for the periods April first, two thousand eight through November thirtieth, two thousand nine, funds within amounts appropriated shall be transferred and deposited and credited to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of funding the state share of rate adjustments made to public and voluntary hospitals in accordance with paragraphs (i) and (j) of subdivision one of section twenty-eight hundred seven-c of this article.

2. Notwithstanding any inconsistent provision of law, rule or regulation, any funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, as a result of surcharges, assessments or other obligations during the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, which are unused or uncommitted for distributions pursuant to this section shall be reserved and accumulated from year to year by the commissioner and, within amounts appropriated, transferred and deposited into the special revenue funds - other, miscellaneous special revenue fund - 339, child health insurance account or any successor fund or account, for purposes of distributions to implement the child health insurance program established pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for periods on and after January first, two thousand one; provided, however, funds reserved and accumulated for priority distributions pursuant to subparagraph

(iii) of paragraph (c) of subdivision one of this section shall not be transferred and deposited into such account pursuant to this subdivision; and provided further, however, that any unused or uncommitted pool funds accumulated and allocated pursuant to paragraph (j) of subdivision one of this section shall be distributed for purposes of the health information and quality improvement act of 2000.

3. Revenue from distributions pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

§ 2807-m. Distribution of the professional education pools. 1.

Definitions. For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

(a) "Clinical research" means patient-oriented research, epidemiologic and behavioral studies, or outcomes research and health services research that is approved by an institutional review board by the time the clinical research position is filled.

(b) "Clinical research plan" means a plan submitted by a consortium or teaching general hospital for a clinical research position which demonstrates, in a form to be provided by the commissioner, the following:

(i) financial support for overhead, supervision, equipment and other resources equal to the amount of funding provided pursuant to subparagraph (i) of paragraph (b) of subdivision five-a of this section by the teaching general hospital or consortium for the clinical research position;

(ii) experience the sponsor-mentor and teaching general hospital has in clinical research and the medical field of the study;

(iii) methods, data collection and anticipated measurable outcomes of

the clinical research to be performed;

(iv) training goals, objectives and experience the researcher will be provided to assess a future career in clinical research;

(v) scientific relevance, merit and health implications of the research to be performed;

(vi) information on potential scientific meetings and peer review journals where research results can be disseminated;

(vii) clear and comprehensive details on the clinical research position;

(viii) qualifications necessary for the clinical research position and strategy for recruitment;

(ix) non-duplication with other clinical research positions from the same teaching general hospital or consortium;

(x) methods to track the career of the clinical researcher once the term of the position is complete; and

(xi) any other information required by the commissioner to implement subparagraph (i) of paragraph (b) of subdivision five-a of this section.

(xii) The clinical review plan submitted in accordance with this paragraph may be reviewed by the commissioner in consultation with experts outside the department of health.

(c) "Clinical research position" means a post-graduate residency position which:

(i) shall not be required in order for the researcher to complete a graduate medical education program;

(ii) may be reimbursed by other sources but only for costs in excess of the funding distributed in accordance with subparagraph (i) of paragraph (b) of subdivision five-a of this section;

(iii) shall exceed the minimum standards that are required by the residency review committee in the specialty the researcher has trained or is currently training;

(iv) shall not be previously funded by the teaching general hospital or supported by another funding source at the teaching general hospital in the past three years from the date the clinical research plan is submitted to the commissioner;

(v) may supplement an existing research project;

(vi) shall be equivalent to a full-time position comprising of no less than thirty-five hours per week for one or two years;

(vii) shall provide, or be filled by a researcher who has formalized instruction in clinical research, including biostatistics, clinical trial design, grant writing and research ethics;

(viii) shall be supervised by a sponsor-mentor who shall either (A) be employed, contracted for employment or paid through an affiliated faculty practice plan by a teaching general hospital which has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; (B) maintain a faculty appointment at a medical, dental or podiatric school located in New York state that has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; or (C) be collaborating in the clinical research plan with a researcher from another institution that has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; and

(ix) shall be filled by a researcher who is (A) enrolled or has completed a graduate medical education program, as defined in paragraph (i) of this subdivision; (B) a United States citizen, national, or permanent resident of the United States; and (C) a graduate of a medical, dental or podiatric school located in New York state, a graduate or resident in a graduate medical education program, as defined in paragraph (i) of this subdivision, where the sponsoring institution, as defined in paragraph (q) of this subdivision, is located in New York state, or resides in New York state at the time the clinical research plan is submitted to the commissioner.

(d) "Consortium" means an organization or association, approved by the commissioner in consultation with the council, of general hospitals which provide graduate medical education, together with any affiliated site; provided that such organization or association may also include other providers of health care services, medical schools, payors or consumers, and which meet other criteria pursuant to subdivision six of this section.

(e) "Council" means the New York state council on graduate medical education.

(f) "Direct medical education" means the direct costs of residents,

interns and supervising physicians.

(g) "Distribution period" means each calendar year set forth in subdivision two of this section.

(h) "Faculty" means persons who are employed by or under contract for employment with a teaching general hospital or are paid through a teaching general hospital's affiliated faculty practice plan and maintain a faculty appointment at a medical school. Such persons shall not be limited to persons with a degree in medicine.

(i) "Graduate medical education program" means a post-graduate medical education residency in the United States which has received accreditation from a nationally recognized accreditation body or has been approved by a nationally recognized organization for medical, osteopathic, podiatric or dental residency programs including, but not limited to, specialty boards.

(j) "Indirect medical education" means the estimate of costs, other than direct costs, of educational activities in teaching hospitals as determined in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs for reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare).

(k) "Medicare" means the methodology used for purposes of reimbursing inpatient hospital services provided to beneficiaries of title XVIII of the federal social security act.

(l) "Primary care" residents specialties shall include family medicine, general pediatrics, primary care internal medicine, and primary care obstetrics and gynecology. In determining whether a residency is in primary care, the commissioner shall consult with the council.

(m) "Regions", for purposes of this section, shall mean the regions as defined in paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six. For purposes of distributions pursuant to subdivision five-a of this section, except distributions made in accordance with paragraph (a) of subdivision five-a of this section, "regions" shall be defined as New York city and the rest of the state.

(n) "Regional pool" means a professional education pool established on a regional basis by the commissioner from funds available pursuant to

sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article.

(o) "Resident" means a person in a graduate medical education program which has received accreditation from a nationally recognized accreditation body or in a program approved by any other nationally recognized organization for medical, osteopathic or dental residency programs including, but not limited to, specialty boards.

(p) "Shortage specialty" means a specialty determined by the commissioner, in consultation with the council, to be in short supply in the state of New York.

(q) "Sponsoring institution" means the entity that has the overall responsibility for a program of graduate medical education. Such institutions shall include teaching general hospitals, medical schools, consortia and diagnostic and treatment centers.

(r) "Weighted resident count" means a teaching general hospital's total number of residents as of July first, nineteen hundred ninety-five, including residents in affiliated non-hospital ambulatory settings, reported to the commissioner. Such resident counts shall reflect the weights established in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner for purposes of implementing subdivision twenty-five of section twenty-eight hundred seven-c of this article and in effect on July first, nineteen hundred ninety-five. Such weights shall not be applied to specialty hospitals, specified by the commissioner, whose primary care mission is to engage in research, training and clinical care in specialty eye and ear, special surgery, orthopedic, joint disease, cancer, chronic care or rehabilitative services.

(s) "Adjustment amount" means an amount determined for each teaching hospital for periods prior to January first, two thousand nine by:

(i) determining the difference between (A) a calculation of what each teaching general hospital would have been paid if payments made pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three were based solely on the case mix of persons eligible for medical assistance under the medical assistance program pursuant to title eleven of article five of the social services law who are enrolled in health maintenance

organizations and persons paid for under the family health plus program enrolled in approved organizations pursuant to title eleven-D of article five of the social services law during those years, and (B) the actual payments to each such hospital pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three.

(ii) reducing proportionally each of the amounts determined in subparagraph (i) of this paragraph so that the sum of all such amounts totals no more than one hundred million dollars;

(iii) further reducing each of the amounts determined in subparagraph (ii) of this paragraph by the amount received by each hospital as a distribution from funds designated in paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three, except that if such amount was provided to a consortium then the amount of the reduction for each hospital in the consortium shall be determined by applying the proportion of each hospital's amount determined under subparagraph (i) of this paragraph to the total of such amounts of all hospitals in such consortium to the consortium award;

(iv) further reducing each of the amounts determined in subparagraph (iii) of this paragraph by the amounts specified in paragraph (t) of this subdivision; and

(v) dividing each of the amounts determined in subparagraph (iii) of this paragraph by seven.

(t) "Extra reduction amount" shall mean an amount determined for a teaching hospital for which an adjustment amount is calculated pursuant to paragraph (s) of this subdivision that is the hospital's proportionate share of the sum of the amounts specified in paragraph (u) of this subdivision determined based upon a comparison of the hospital's remaining liability calculated pursuant to paragraph (s) of this subdivision to the sum of all such hospital's remaining liabilities.

(u) "Allotment amount" shall mean an amount determined for teaching hospitals as follows:

(i) for a hospital for which an adjustment amount pursuant to paragraph (s) of this subdivision does not apply, the amount received by the hospital pursuant to paragraph (a) of subdivision five of this

section attributable to the period January first, two thousand three through December thirty-first, two thousand three, or

(ii) for a hospital for which an adjustment amount pursuant to paragraph (s) of this subdivision applies and which received a distribution pursuant to paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three that is greater than the hospital's adjustment amount, the difference between the distribution amount and the adjustment amount.

2. Regional pools. (a) The commissioner shall establish regional pools for each of the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand from funds available pursuant to sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article.

(b) For periods prior to January first, two thousand nine, each regional pool shall be distributed on a monthly basis to teaching general hospitals for costs associated with graduate medical education provided by such teaching general hospitals in accordance with the distribution methodology set forth in subdivision three of this section; provided however, teaching general hospitals with a resident count of zero as of July first of the year preceding the distribution period shall not be eligible for distributions pursuant to this section. General hospitals may elect to have their distribution paid through the consortium.

3. Regional pool distributions. (a) Distributions to teaching general hospitals shall be made from the regional pools described in subdivision two of this section for each period prior to January first, two thousand nine, less amounts set aside pursuant to subdivision five of this section. To be eligible to participate in distributions pursuant to this section, a teaching general hospital and consortium must be in compliance with graduate medical education reporting requirements set

forth in subdivision four of this section.

(b) For periods prior to January first, two thousand nine, each teaching general hospital in a region shall have a proxy calculated for its graduate medical education costs as follows:

(i) The direct medical education portion of the proxy shall be the product of: the teaching general hospital's medicare direct medical education payment amount per resident for federal fiscal year nineteen hundred ninety-five--ninety-six and the teaching general hospital's weighted resident count as of July first, nineteen hundred ninety-five and the teaching general hospital's inpatient percentage of total costs and percentage of inpatient days, excluding medicare days, patient days eligible for payments by governmental agencies, the comprehensive motor vehicle insurance reparations act, workers' compensation law, volunteer firefighters' benefit law, volunteer ambulance workers' benefit law and self-pay patient days, to total days as such costs and days are reported in the institutional cost report for periods ending March thirty-first, nineteen hundred ninety-five, June thirtieth, nineteen hundred ninety-five or December thirty-first, nineteen hundred ninety-five, whichever is applicable. The teaching general hospital's medicare direct medical education payment amount for purposes of this calculation shall not exceed one hundred fifty percent of the regional average per resident amount for the region in which the teaching general hospital is located.

(ii) The indirect medical education portion of the proxy for a teaching general hospital shall be calculated using the medicare resident per bed formula in existence on June thirtieth, nineteen hundred ninety-six, except the teaching general hospital's weighted resident count as of July first, nineteen hundred ninety-five and number of certified acute care beds as of January first, nineteen hundred ninety-five shall be used in the application of the formula. The formula result shall be applied to the teaching general hospital's applicable case mix neutral and wage adjusted medicare standardized rate amount for federal fiscal year nineteen hundred ninety-five--ninety-six. The result of this application shall be multiplied by the teaching general hospital's total number of discharges as reported in the institutional cost report for periods ending March thirty-first, nineteen hundred ninety-five, June thirtieth, nineteen hundred ninety-five or December

thirty-first, nineteen hundred ninety-five, whichever is applicable, excluding discharges relating to patients eligible for medicare, payments by governmental agencies, payments pursuant to the comprehensive motor vehicle insurance reparations act, payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, and self-pay patients, and applicable weighting factors developed in accordance with subdivision three of section twenty-eight hundred seven-c of this article as in effect in nineteen hundred ninety-five. For teaching general hospitals which are specialty hospitals reimbursed on a per diem basis, the applicable case mix neutral and wage adjusted medicare standardized rate amount for purposes of this calculation shall be the amount determined for the majority of teaching general hospitals within a region.

(iii) The teaching general hospital's graduate medical education proxy shall equal the sum of its direct medical education proxy and indirect medical education proxy.

(c) For periods prior to January first, two thousand nine, a distribution amount for each teaching general hospital shall be calculated from the applicable regional pool described in subdivision two of this section as adjusted pursuant to paragraph (d) of this subdivision based upon its percentage of the regional total of the graduate medical education proxies, except that for purposes of this paragraph the statewide amount used to compute such distribution amounts shall be four hundred ninety million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand two and two hundred forty-five million dollars for the period January first, two thousand three through June thirtieth, two thousand three, less amounts set aside each period pursuant to subdivision seven of this section.

(d) For periods prior to January first, two thousand nine, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraph (c) of this subdivision adjusted by a reduction amount that is determined as follows:

(i) the commissioner shall establish a reduction percentage by dividing twenty-seven million dollars each year for the period January

first, two thousand through December thirty-first, two thousand ten and six million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, by the sum of initial hospital distribution amounts calculated pursuant to paragraph (c) of this subdivision;

(ii) the commissioner shall multiply the reduction percentage by the amount calculated pursuant to paragraph (c) of this subdivision for each teaching general hospital;

(iii) each teaching general hospital shall have its initial distribution amount as determined pursuant to paragraph (c) of this subdivision reduced by an amount up to the amount calculated pursuant to subparagraph (ii) of this paragraph and subject to the requirements of subparagraph (iv) of this paragraph, provided, however, that if the sum of reduction amounts for all facilities thus calculated is less than twenty-seven million dollars on a statewide basis each year for the period January first, two thousand through December thirty-first, two thousand ten and six million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, the commissioner may increase the reduction percentage subject to the provisions of subparagraph (iv) of this paragraph so that the sum of the reduction amounts for all facilities is twenty-seven million dollars each year for the period January first, two thousand through December thirty-first, two thousand ten and six million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(iv) for distribution periods prior to January first, two thousand eleven, an individual hospital's reduction amount shall not exceed the hospital's projected losses for treating medicaid and uninsured patients after all other projected medical assistance, including all other projected disproportionate share payments for the applicable period. Such cap on the reduction amount shall also not be reconciled to reflect actual medicaid and uninsured losses for the applicable period.

(e) Effective April first, two thousand four through December thirty-first, two thousand eight, the distribution amount calculated pursuant to paragraphs (c) and (d) of this subdivision for each non-public teaching general hospital shall be reduced by the amount

calculated and included in rates pursuant to paragraph (d) of subdivision twenty-five of section twenty-eight hundred seven-c of this article.

(f) Effective January first, two thousand five through December thirty-first, two thousand eight, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraphs (c), (d) and (e) of this subdivision and reduced by its adjustment amount calculated pursuant to paragraph (s) of subdivision one of this section and, for distributions for the period January first, two thousand five through December thirty-first, two thousand five, further reduced by its extra reduction amount calculated pursuant to paragraph (t) of subdivision one of this section.

4. Reporting requirements. Each teaching general hospital and consortium shall furnish to the department such reports and information as may be required by the commissioner to implement this section and to assess the cost, quality and health system needs for graduate medical education, including, but not limited to:

(a) each teaching general hospital and site other than a general hospital at which residents receive training shall describe annually its graduate medical education program or programs and report the number of residents in each program; and

(b) each consortium shall provide annually a list of the teaching general hospitals and sites other than general hospitals at which residents receive training participating in the consortium as members and an implementation report relating to achievement of the goals and objectives of the consortium plan; and

(c) each teaching general hospital and sponsoring institution shall jointly prepare and submit to the commissioner on an annual basis an institutional graduate medical education budget reflecting all sources of graduate medical education revenue and expenditures for a calendar year. In a form and manner to be specified by the commissioner, such budget shall be prepared and reviewed by the residency training director and certified by the chief executive officer as to accuracy and completeness prior to submission to the commissioner. Such budget shall be submitted to the commissioner by February first, two thousand nine

for the two thousand nine calendar year and each February first, thereafter.

5. Supplemental distributions. (a) Up to thirty-one million dollars annually for the periods January first, two thousand through December thirty-first, two thousand three, and up to twenty-five million dollars plus the sum of the amounts specified in paragraph (n) of subdivision one of this section for the period January first, two thousand five through December thirty-first, two thousand five, and up to thirty-one million dollars annually for the period January first, two thousand six through December thirty-first, two thousand seven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section for supplemental distributions in each such region to be made by the commissioner to consortia and teaching general hospitals in accordance with a distribution methodology developed in consultation with the council and specified in rules and regulations adopted by the commissioner.

(b) Funds available shall be distributed to consortia and teaching general hospitals that substantially meet the following training goals and objectives:

- (i) reducing the number of graduate medical education programs and/or the number of residents in such programs;
- (ii) increasing the number of residents training in underserved areas;
- (iii) increasing the number of residents training in ambulatory care facilities;
- (iv) improving the quality of training programs;
- (v) increasing training of minorities; and
- (vi) such other factors as may be specified in rules and regulations adopted by the commissioner in consultation with the council.

The distribution of funds pursuant to this subdivision shall not be conditioned on a consortia or teaching general hospital reducing the number of graduate medical education programs and/or the number of residents in such program.

(c) In the event that funds available under this subdivision are not distributed to consortia or teaching general hospitals in accordance with this subdivision, such funds shall be distributed to teaching

general hospitals in accordance with the methodology described in subdivision three of this section.

(d) Notwithstanding any other provision of law or regulation, for the period January first, two thousand five through December thirty-first, two thousand five, the commissioner shall distribute as supplemental payments the allotment specified in paragraph (n) of subdivision one of this section.

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars.

(ii) For periods on and after January first, two thousand nine, supplemental distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall no longer be made and the provisions of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be null and void.

(b) Empire clinical research investigator program (ECRIP). Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, through March

thirty-first, two thousand eleven, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-nine, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be available for distribution as follows:

Distributions shall first be made to consortia and teaching general hospitals for the empire clinical research investigator program (ECRIP) to help secure federal funding for biomedical research, train clinical researchers, recruit national leaders as faculty to act as mentors, and train residents and fellows in biomedical research skills based on hospital-specific data submitted to the commissioner by consortia and teaching general hospitals in accordance with clause (G) of this subparagraph. Such distributions shall be made in accordance with the following methodology:

(A) The greatest number of clinical research positions for which a consortium or teaching general hospital may be funded pursuant to this subparagraph shall be one percent of the total number of residents training at the consortium or teaching general hospital on July first, two thousand eight for the period January first, two thousand nine through December thirty-first, two thousand nine rounded up to the nearest one position.

(B) Distributions made to a consortium or teaching general hospital

shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not exceed the total amount appropriated for purposes of this paragraph. If the repeated reduction of the total number of clinical research positions in the region by one-half does not render a total funding amount that is equal to or less than the total amount reserved for that region within the appropriation, the funding for each clinical research position in that region shall be reduced proportionally in one thousand dollar increments until the total dollar amount for the total number of clinical research positions in that region does not exceed the total amount reserved for that region within the appropriation. Any reduction in funding will be effective for the duration of the award. No clinical research positions that continue from and were funded in prior distribution periods shall be eliminated or reduced by such methodology.

(D) Each consortium or teaching general hospital shall receive its annual distribution amount in accordance with the following:

(I) Each consortium or teaching general hospital with a one-year ECRIP award shall receive its annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(II) Each consortium or teaching general hospital with a two-year ECRIP award shall receive its first annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. Each consortium or teaching general hospital will receive its second annual distribution amount in full upon completion of the requirements set forth in item (III) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(E) Each consortium or teaching general hospital receiving distributions pursuant to this subparagraph shall reserve seventy-five thousand dollars to primarily fund salary and fringe benefits of the clinical research position with the remainder going to fund the development of faculty who are involved in biomedical research, training and clinical care.

(F) Undistributed or returned funds available to fund clinical research positions pursuant to this paragraph for a distribution period shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of

subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided upon completion of one-half of the award term;

(IV) A final report detailing training experiences, accomplishments, activities and performance of the clinical researcher, and data, methods, results and analyses of the clinical research plan shall be provided three months after the clinical research position ends; and

(V) Tracking information concerning past researchers, including but not limited to (A) background information, (B) employment history, (C) research status, (D) current research activities, (E) publications and presentations, (F) research support, and (G) any other information necessary to track the researcher; and

(VI) Any other data or information required by the commissioner to implement this subparagraph.

(H) Notwithstanding any inconsistent provision of this subdivision, for periods on and after April first, two thousand thirteen, ECRIP grant awards shall be made in accordance with rules and regulations promulgated by the commissioner. Such regulations shall, at a minimum:

(1) provide that ECRIP grant awards shall be made with the objective of securing federal funding for biomedical research, training clinical researchers, recruiting national leaders as faculty to act as mentors, and training residents and fellows in biomedical research skills;

(2) provide that ECRIP grant applicants may include interdisciplinary research teams comprised of teaching general hospitals acting in collaboration with entities including but not limited to medical centers, hospitals, universities and local health departments;

(3) provide that applications for ECRIP grant awards shall be based on

such information requested by the commissioner, which shall include but not be limited to hospital-specific data;

(4) establish the qualifications for investigators and other staff required for grant projects eligible for ECRIP grant awards; and

(5) establish a methodology for the distribution of funds under ECRIP grant awards.

(c) Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated

regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians identified by general hospitals.

(iv) In addition to the funds allocated under this paragraph, for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(vi) Notwithstanding any provision of law to the contrary, and subject to the extension of the Health Care Reform Act of 1996, sufficient funds shall be available for the purposes described in subdivision ten of this section in amounts necessary to fund the remaining year commitments for awards made pursuant to subparagraphs (iv) and (v) of this paragraph.

(d) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two

thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four million three hundred sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four million three hundred sixty thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians to provide

services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

(e) Work group. For funding available pursuant to paragraphs (c), (d) and (e) of this subdivision:

(i) The department shall appoint a work group from recommendations made by associations representing physicians, general hospitals and other health care facilities to develop a streamlined application process by June first, two thousand twelve.

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The department shall act on an application within thirty days of receipt of a complete application.

(f) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, five hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four hundred eighty-seven thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty-six

through March thirty-first, two thousand twenty-nine, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter into agreements with one or more organizations to conduct such study based on a request for proposal process.

(g) Scholars in medicine and science and scholarships in medicine programs. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its scholars in medicine and science and scholarships in medicine programs including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all

medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

(h) In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

5-b. Other graduate medical education reforms. Any funds specifically appropriated for the purposes of this subdivision shall be used to fund innovative graduate medical education reforms to be determined by the commissioner in consultation with the council, including, but not limited to, (a) development of primary care residency and specialty position training tracks for graduates to serve rural or inner-city communities, (b) development of regional pilot network programs to affiliate major academic centers with community teaching general hospitals, (c) support for faculty development programs, including designating faculty to mentor students and residents in primary care, (d) support training in fields which serve the geriatric population; (e) increase training in cultural competence, (f) promote training of physicians who will serve persons with developmental disabilities, and (g) any other reforms necessary to improve patient care management, interdisciplinary training, or quality in graduate medical education programs. Such funding shall be distributed to consortia and teaching general hospitals in each region on a competitive basis pursuant to a request for proposal process.

6. Consortia. (a) A consortium must:

(i) have a governing body and such committees as appropriate which should be responsible for the policy coordination and administration of residency programs and which provides all members of the consortium an opportunity to participate in the establishment of consortium policy goals and objectives;

(ii) have procedures and criteria for processing applications by health care providers in the region for participation in the consortium;

(iii) establish policies to evaluate and to maintain and improve the quality of training programs;

(iv) have a mechanism for resolving educational and financial allocation disputes among participating members; and

(v) comply with such further requirements as the commissioner may reasonably require for purposes of implementing this section to achieve state policy goals and objectives regarding graduate medical education.

(b) Nothing in this section shall preclude a consortium from having members from different regions and from allocating regional pool distributions among regions.

(c) To the extent consortia might be anti-competitive within the meaning and intent of the federal and state antitrust laws, it is the intent of the legislature to supplant competition with such arrangements to the extent necessary to accomplish the purposes of this section, and provide state action immunity under the federal antitrust laws with respect to the planning, implementation and operation of consortia and participation therein by hospitals, other providers of health care services, medical schools, payors and consumers.

(d) Each approved consortium shall submit a plan for each period defined in subdivision two of this section for approval by the commissioner, in consultation with the council, for allocation of funds collected pursuant to paragraph (c) of subdivision three of this section to participating general hospitals which provide graduate medical education and sites other than general hospitals at which residents receive training.

8. Revenue from distributions pursuant to this section shall be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article and for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article.

10. Physician loan repayment program. (a) Beginning January first, two thousand eight, the commissioner is authorized, within amounts available pursuant to subdivision five-a of this section, to make loan repayment awards to primary care physicians or other physician specialties determined by the commissioner to be in short supply,

licensed to practice medicine in New York state, who agree to practice for at least five years in an underserved area, as determined by the commissioner. Such physician shall be eligible for a loan repayment award of up to one hundred fifty thousand dollars over a five year period distributed as follows: fifteen percent of total loan debt not to exceed twenty thousand dollars for the first year; fifteen percent of total loan debt not to exceed twenty-five thousand dollars for the second year; twenty percent of total loan debt not to exceed thirty-five thousand dollars for the third year; and twenty-five percent of total loan debt not to exceed thirty-five thousand dollars per year for the fourth year; and any unpaid balance of the total loan debt not to exceed the maximum award amount for the fifth year of practice in such area.

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

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

(d) The commissioner is authorized to apply any funds available for purposes of paragraph (a) of this subdivision for use as matching funds for federal grants for the purpose of assisting states in operating loan repayment programs pursuant to section three hundred thirty-eight I of the public health service act.

(e) The commissioner may postpone, change or waive the service obligation and repayment amounts set forth in paragraphs (a) and (c), respectively of this subdivision in individual circumstances where there is compelling need or hardship.

(f)(i) When a physician is not actually practicing in an underserved area, he or she shall be deemed to be practicing in an underserved area

if he or she practices in a facility or physician's office that primarily serves an underserved population as determined by the commissioner, without regard to whether the population or the facility or physician's office is located in an underserved area.

(ii) In making criteria and determinations as to whether an area is an underserved area or whether a facility or physician's office primarily serves an underserved population, the commissioner may make separate criteria and determinations for different specialties.

11. The commissioner shall conduct a study of (i) the need for expansion of the physician loan repayment program under subdivision ten of this section to include dentists, midwives, nurse practitioners, and physician assistants; (ii) the level of funding appropriate for that expansion; and (iii) appropriate sources of funding for the future of the program and the expansion. The study may include examination of possible expansion of other programs to recruit people to enter health care professions and serve in underserved areas. The commissioner shall conduct the study in consultation with representatives of the affected professions, educational institutions and training programs that educate and train people for those professions, appropriate health care providers, affected communities and other interested parties. The commissioner shall report to the governor and the legislature on the findings of the study and recommendations by December first, two thousand eight.

12. Notwithstanding any provision of law to the contrary, applications submitted on or after April first, two thousand sixteen, for the physician loan repayment program pursuant to paragraph (c) of subdivision five-a of this section and subdivision ten of this section or the physician practice support program pursuant to paragraph (d) of subdivision five-a of this section, shall be subject to the following changes:

(a) Awards shall be made from the total funding available for new awards under the physician loan repayment program and the physician practice support program, with neither program limited to a specific funding amount within such total funding available;

(b) An applicant may apply for an award for either physician loan

repayment or physician practice support, but not both;

(c) An applicant shall agree to practice for three years in an underserved area and each award shall provide up to forty thousand dollars for each of the three years; and

(d) To the extent practicable, awards shall be timed to be of use for job offers made to applicants.

§ 2807-n. Palliative care education and training. 1. Definitions. The following words or phrases as used in this section shall have the following meanings:

(a) "Palliative care" shall mean (i) the active, interdisciplinary care of patients with advanced, life limiting illness, focusing on relief of distressing physical and psychosocial symptoms and meeting spiritual needs. Its goal is achievement of the best quality of life for patients and families as defined by paragraph (b) of subdivision two of section four thousand twelve-b of this chapter; and (ii) it shall also include similar care for patients with chronic or acute pain.

(b) "Palliative care certified medical school" shall mean a medical school in the state which is an institution granting a degree of doctor of medicine or doctor of osteopathic medicine in accordance with regulations by the commissioner of education under subdivision two of section sixty-five hundred twenty-four of the education law, and which meets standards defined by the commissioner of health, after consultation with the council, pursuant to regulations, and used to determine whether a medical school is eligible for funding under this section.

(c) "Palliative care certified residency program" shall mean a graduate medical education program in the state which has received accreditation from a nationally recognized accreditation body for medical or osteopathic residency programs, and which meets standards defined by the commissioner, after consultation with the council, pursuant to regulations, and used to determine whether a residency training program is eligible for funding under this section.

(d) "New York state palliative care education and training council" or "council" shall mean the New York state palliative care education and training council established pursuant to subdivision six of this

section.

2. Grants for undergraduate medical education in palliative care. (a) The commissioner is authorized, within amounts appropriated for such purpose to make grants to palliative care certified medical schools to enhance the study of palliative care, increase the opportunities for undergraduate medical education in palliative care and encourage the education of physicians in palliative care.

(b) Grant proceeds under this subdivision may be used for faculty development in palliative care; recruitment of faculty with expertise in palliative care; costs incurred teaching medical students at hospital-based sites, non-hospital-based ambulatory care settings, palliative care sites, hospices, certified home health agencies, licensed long term home health care programs and AIDS home care programs including, but not limited to, personnel, administration and student-related expenses; expansion or development of programs that train physicians in palliative care; and other innovative programs designed to increase the competency of medical students to provide hospice or palliative care.

(c) Grants under this subdivision shall be awarded by the commissioner through a competitive application process to the council. The council shall make recommendations for funding to the commissioner. In making awards, consideration shall be given to applicants who:

(i) plan to incorporate palliative care longitudinally throughout the medical school curriculum according to professionally recognized standards including, but not limited to, a plan that covers the seven domains identified in the Palliative Education Assessment Tool (PEAT) as developed by the New York Academy of Medicine and the Associated Medical Schools of New York State and Weill Cornell Medical College;

(ii) function in collaboration with hospital-based palliative care programs and non-hospital-based sites; and

(iii) make complementary efforts to recruit or train qualified faculty in palliative care education.

(d) The intent of this subdivision is to augment or increase palliative care undergraduate medical education. Grant funding shall not be used to offset existing expenditures that the medical school has obligated or intends to obligate for palliative care education programs.

3. Grants for graduate medical education in palliative care. (a) The commissioner is authorized, within amounts appropriated for such purpose to make grants in support of palliative care certified residency education programs to establish or expand education in palliative care for graduate medical education, and to increase the opportunities for trainee education in palliative care in hospital-based palliative care programs or non-hospital-based care sites.

(b) Grants under this subdivision for graduate medical education and education in palliative care may be used for administration, faculty recruitment and development, start-up costs and costs incurred teaching palliative care in hospital-based palliative care programs or non-hospital-based care sites, including, but not limited to, personnel, administration and trainee related expenses and other expenses judged reasonable and necessary by the commissioner.

(c) Grants under this subdivision shall be awarded by the commissioner through a competitive application process to the council. The council shall make recommendations for funding to the commissioner. In making awards, the commissioner shall consider the extent to which the applicant:

(i) plans to incorporate palliative care longitudinally throughout the residency training program according to professionally recognized standards including, but not limited to, a plan that covers the seven domains identified in the Palliative Education Assessment Tool (PEAT) as developed by the New York Academy of Medicine and the Associated Medical Schools of New York State and Weill Cornell Medical College;

(ii) functions in collaboration with hospital-based palliative care programs or non-hospital-based sites, or both; and

(iii) makes complementary efforts to recruit or train qualified faculty in palliative care education.

(d) The intent of this subdivision is to augment or increase training in palliative care during residency. Grant funding shall not be used to offset existing expenditures the institution or program has obligated or intends to obligate for such training programs.

4. Centers for palliative care excellence. The commissioner shall designate organizations licensed pursuant to this article and article

forty of this chapter, upon successful application, as centers for palliative care excellence. Such designations shall be pursuant to an application as designed by the department, and based on service, staffing and other criteria as developed by the council. Such centers of excellence shall provide specialized palliative care, treatment, education and related services. Designation as a center for palliative care excellence shall not entitle a center to enhanced reimbursement, but may be utilized in outreach and other promotional activities.

5. Palliative care practitioner resource centers. The commissioner, in consultation with the council, may designate palliative care practitioner resource centers (a "resource center"). A resource center may be statewide or regional, and shall act as a source of technical information and guidance for practitioners on the latest palliative care strategies, therapies and medications. The department, in consultation with the council, may contract with not-for-profit organizations or associations to establish and manage resource centers. A resource center may charge a fee to defray the cost of the service.

6. New York state palliative care education and training council. (a) The New York state palliative care education and training council is established in the department as an expert panel in palliative medicine, education and training. Its members shall be appointed by the commissioner. The commissioner shall seek recommendations for appointments to such council from New York state-based health care professional, consumer, medical institutional and medical educational leaders. Members of the council shall include: nine representatives of medical schools and hospital organizations; two representatives of medical academies; two patient advocates; individual representatives of an organization broadly representative of physicians, internal medicine, family physicians, nursing, social work, hospice, home care, neurology, psychiatry, pediatrics, obstetrics-gynecology, surgery, and the hospital philanthropic community; and the executive director or a member of the governor's taskforce on life and the law and of the New York state council on graduate medical education. Members shall have expertise in palliative care or pain management. Members shall serve a term of three years with renewable terms. Members shall receive no compensation for

their services, but shall be allowed actual and necessary expenses in the performance of their duties.

(b) A chairperson and vice-chairperson of the council shall be elected annually by the council. The council shall meet upon the call of the chairperson, and may adopt bylaws consistent with this section.

(c) The commissioner shall designate such employees and provide other resources of the department as are reasonably necessary to provide support services to the council. The council, acting by the chair of the council, may employ additional staff and consultants and incur other expenses to carry out its duties, to be paid from amounts which may be made available to the council for that purpose.

(d) The council may provide technical information and guidance for practitioners on the latest palliative care strategies, therapies and medications.

7. Reports. The commissioner, in conjunction with the council, shall prepare and submit a report to the governor and the legislature, on or before February first, two thousand ten reporting the results and evaluating the effectiveness of this section.

§ 2807-o. Early intervention services pool. 1. Definitions. The following words or phrases as used in this section shall have the following meanings:

(a) "Early intervention services" shall mean services delivered to an eligible child, pursuant to an individualized family service plan under the early intervention program.

(b) "Early intervention program" shall mean the early intervention program for toddlers with disabilities and their families as created by title two-A of article twenty-five of this chapter.

(c) "Municipality" shall mean any county outside of the city of New York or the city of New York.

2. Payments for early intervention services. (a) The commissioner shall, from funds allocated for such purpose under paragraph (g) of subdivision six of section twenty-eight hundred seven-s of this article, make payments to municipalities and the state for the delivery of early

intervention services.

(b) Payments under this subdivision shall be made to municipalities and the state by the commissioner. Each municipality and the state of New York shall receive a share of such payments equal to its proportionate share of the total approved statewide dollars not reimbursable by the medical assistance program paid to providers of early intervention services by the state and municipalities on account of early intervention services in the last complete state fiscal year for which such data is available.

§ 2807-p. Comprehensive diagnostic and treatment centers indigent care program. 1. (a) For periods prior to July first, two thousand three, and on and after July first, two thousand five the commissioner is authorized to make payments to eligible diagnostic and treatment centers, to the extent of funds available therefor, up to forty-eight million dollars annually, to assist in meeting losses resulting from uncompensated care. The amount of funds available for such payments pursuant to subdivision four of this section shall be the amount remaining after the allocation provided in section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven as amended by section seventy-five of chapter one of the laws of nineteen hundred ninety-nine.

(b) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment to assist in meeting losses resulting from uncompensated care, provided, however, in the event federal financial participation is not available, the commissioner is authorized to continue to make payments to eligible diagnostic and treatment centers, to the extent of funds available therefor, in accordance with provisions of paragraph (a) of this subdivision and without regard to the provisions of subdivisions four-a and four-b of this section.

(c) Notwithstanding paragraph (a) of this subdivision, subdivision four-c of this section or any other inconsistent provision of this section, distributions made pursuant to this section for annual periods on and after July first, two thousand nine shall be subject to a uniform

reduction of two percent.

(d) The commissioner may require facilities receiving distributions pursuant to this section as a condition of participating in such distributions, to provide reports and data to the department as the commissioner deems necessary to adequately implement the provisions of this section.

2. Definitions. (a) "Eligible diagnostic and treatment centers", for purposes of this section, shall mean voluntary non-profit and publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate losses from disproportionate share of uncompensated care during a base period two years prior to the grant period; provided that for periods on and after January first, two thousand four an eligible diagnostic and treatment center shall not include any voluntary non-profit diagnostic and treatment center controlling, controlled by or under common control with a health maintenance organization, as defined by subdivision one of section forty-four hundred one of this chapter; provided further that for purposes of this section, a health maintenance organization shall not include a prepaid health services plan licensed pursuant to section forty-four hundred three-a of this chapter. For periods on and after July first, two thousand three, the base period and the grant period shall be the calendar year.

(b) "Uncompensated care need", for purposes of this section, means losses from reported self-pay and free visits multiplied by the facility's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

3. (a) During the period January first, nineteen hundred ninety-seven through September thirtieth, nineteen hundred ninety-seven and for each fiscal year period commencing on October first thereafter through December thirty-first, nineteen hundred ninety-nine and for periods on and after January first, two thousand, diagnostic and treatment centers shall be eligible for allocations of funds or for rate adjustments determined in accordance with this section to reflect the needs of the diagnostic and treatment center for the financing of losses resulting

from uncompensated care.

(b) A diagnostic and treatment center qualifying for a distribution or a rate adjustment pursuant to this section shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

(c) To be eligible for an allocation of funds or a rate adjustment pursuant to this section, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The commissioner may retrospectively reduce the allocations of funds or the rate adjustments to a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the grant period in the delivery of comprehensive primary health care services to uncompensated care residents of the community.

4. (a) (i) The total amount of funds to be allocated and distributed for uncompensated care to eligible voluntary non-profit diagnostic and treatment centers for a distribution period prior to July first, two thousand three, and on and after July first, two thousand five through December thirty-first, two thousand six, in accordance with this subdivision shall be limited to thirty-three percent of the funds available therefor pursuant to paragraph (a) of subdivision one of this section and, for the period January first, two thousand seven through December thirty-first, two thousand seven, such distributions shall be limited to sixteen and one-half percent of the funds available therefor.

(ii) The total amount of funds to be allocated and distributed for uncompensated care to eligible publicly sponsored diagnostic and treatment centers for a grant period prior to July first, two thousand three, and on and after July first, two thousand five through December thirty-first, two thousand six, in accordance with this subdivision shall be limited to sixty-seven percent of funds available therefor pursuant to paragraph (a) of subdivision one of this section and, for

the period January first, two thousand seven through December thirty-first, two thousand seven, such distributions shall be limited to thirty-three and one-half percent of the funds available therefor; provided, however, that for periods up through December thirty-first, two thousand seven, forty-one percent of the amount of funds allocated for distribution to eligible publicly sponsored diagnostic and treatment centers shall be available for clinics operating under the auspices of the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended.

(iii) (A) Notwithstanding any inconsistent provision of this paragraph, for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and for periods on and after January first, two thousand through December thirty-first, two thousand two, and for periods on and after January first, two thousand four through December thirty-first, two thousand seven, in the event that federal financial participation is not available for rate adjustments pursuant to this section, diagnostic and treatment centers which received an allowance pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article for the period through December thirty-first, nineteen hundred ninety-six shall receive an annual uncompensated care distribution allocation of funds of not less than the amount that would have been received for any losses associated with the delivery of bad debt and charity care for nineteen hundred ninety-five had the provisions of paragraph (f) of subdivision two of section twenty-eight hundred seven of this article remained in effect, provided, however, that for the period January first, two thousand seven through December thirty-first, two thousand seven, the dollar value of the application of the provisions of this subparagraph for any such diagnostic and treatment center shall be reduced by fifty percent.

(B) For the period January first, two thousand three through June thirtieth, two thousand three, and for the period July first, two thousand three through December thirty-first, two thousand three and in the event that federal financial participation is not available for rate adjustments pursuant to this section, each such diagnostic and treatment center shall receive an uncompensated care distribution allocation of

funds of not less than one-half the amount calculated pursuant to clause (A) of this subparagraph.

(b) (i) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(ii) For periods prior to January first, two thousand eight, if the sum of the nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers or for all eligible public diagnostic and treatment centers or for all clinics operating under the auspices of the New York city health and hospitals corporation is less than the amount allocated for uncompensated care allowances pursuant to paragraph (a) of this subdivision for such diagnostic and treatment centers respectively, the nominal coverage percentages of base year period losses associated with the delivery of uncompensated care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit diagnostic and treatment centers or for public diagnostic and treatment centers or for all clinics operating under the auspices of the New York city health and hospitals corporation in accordance with rules and regulations adopted by the council and approved by the commissioner.

(c) For periods prior to January first, two thousand eight, the uncompensated care allocations of funds for each eligible voluntary non-profit diagnostic and treatment center, as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for voluntary non-profit diagnostic and treatment centers

pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(d) For periods prior to January first, two thousand eight, the uncompensated care allocations of funds for each eligible public diagnostic and treatment center, other than clinics operating under the auspices of the New York city health and hospitals corporation and as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(e) For periods prior to January first, two thousand eight, the uncompensated care grant allocations of funds for each eligible public diagnostic and treatment center operating under the auspices of the New York city health and hospitals corporation, as computed in accordance with paragraph (a) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation pursuant to paragraph (a) of this subdivision to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

(f) For periods prior to January first, two thousand eight, any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with this subdivision

shall be reallocated by the commissioner for distributions to the other classifications based on remaining need.

(g) For periods on and after January first, two thousand seven, the uncompensated care allocations of funds for each eligible diagnostic and treatment center, other than allocations made pursuant to paragraphs (c), (d), (e) or (f) of this subdivision, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for all eligible diagnostic and treatment centers to the total statewide nominal payment amounts for all eligible diagnostic and treatment centers determined in accordance with paragraph (b) of this subdivision applied to the nominal payment amount for each such diagnostic and treatment center.

4-a. (a)(i) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible voluntary non-profit diagnostic and treatment centers in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to seven million five hundred thousand dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to seven million five hundred thousand dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustments for each eligible voluntary non-profit diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for voluntary non-profit diagnostic and treatment centers pursuant to subparagraph (i) of this paragraph, to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(b)(i) For periods on and after July first, two thousand three through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible public diagnostic and treatment centers, other than clinics operated under the auspices of the New York city health and hospitals corporation, in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to nine million dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to eighteen million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to nine million dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustments for each eligible public diagnostic and treatment center, other than clinics operating under the auspices of the New York city health and hospitals corporation, shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, pursuant to subparagraph (i) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers, other than clinics operating under the auspices of the New York city health and hospitals corporation, determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(c)(i) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payments made pursuant to paragraph (b) of subdivision one of this section for eligible public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation, in accordance with subparagraphs (ii) and (iii) of this paragraph, for the following periods in the following aggregate amounts:

(A) For the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars;

(B) For the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million dollars;

(C) For the period January first, two thousand five through June thirtieth, two thousand five, up to six million dollars.

(ii) A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage

of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

(iii) The uncompensated care rate adjustment, for each eligible public diagnostic and treatment center operating under the auspices of the New York city health and hospitals corporation shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation pursuant to subparagraph (i) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers operating under the auspices of the New York city health and hospitals corporation determined in accordance with subparagraph (ii) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(d) (i) Notwithstanding the provisions of paragraph (b) of this subdivision and any other provisions of this chapter, municipalities which received state aid pursuant to article two of this chapter for the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year in support of non-hospital based free-standing or local health department operated general medical clinics shall receive an uncompensated care rate adjustment for the period July first, two thousand three through December thirty-first, two thousand three, of not less than one-half the amount received in the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year for general medical clinics.

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, each such municipality shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to subparagraph (i) of this paragraph.

(iii) For the period January first, two thousand five through June

thirtieth, two thousand five, each such municipality shall receive an annual uncompensated care rate adjustment of not less than the amount calculated pursuant to subparagraph (i) of this paragraph.

(e) (i) Notwithstanding any inconsistent provision of this subdivision, for the period July first, two thousand three through December thirty-first, two thousand three, diagnostic and treatment centers which received an allowance pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article for the period through December thirty-first, nineteen hundred ninety-six shall receive an uncompensated care rate adjustment of not less than one-half the amount that would have been received for any losses associated with the delivery of bad debt and charity care for nineteen hundred ninety-five had the provisions of paragraph (f) of subdivision two of section twenty-eight hundred seven of this article remained in effect.

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, each such diagnostic and treatment center shall receive an uncompensated care rate adjustment of not less than twice the amount calculated pursuant to subparagraph (i) of this paragraph.

(iii) For the period January first, two thousand five through June thirtieth, two thousand five, each such diagnostic and treatment center shall receive an annual uncompensated care rate adjustment of not less than the amount calculated pursuant to subparagraph (i) of this paragraph, and shall be subject to subsequent adjustment or reconciliation.

(f) Any residual amount allocated for distribution to a classification of diagnostic and treatment centers in accordance with this subdivision shall be reallocated by the commissioner for distributions to the other classifications based on remaining need.

4-b. (a) For periods on and after July first, two thousand three, through June thirtieth, two thousand five, funds shall be made available for adjustments to rates of payment made pursuant to paragraph (b) of subdivision one of this section for eligible diagnostic and treatment centers with less than two years of operating experience, and diagnostic and treatment centers which have received certificate of need approval

on applications which indicate a significant increase in uninsured visits, for the following periods and in the following aggregate amounts:

(i) For the period July first, two thousand three through December thirty-first, two thousand three, up to one million five hundred thousand dollars;

(ii) For the period January first, two thousand four through December thirty-first, two thousand four, up to three million dollars;

(iii) For the period January first, two thousand five through June thirtieth, two thousand five, up to one million five hundred thousand dollars.

(b) To be eligible for a rate adjustment pursuant to this section, a diagnostic and treatment center shall be a voluntary, non-profit or publicly sponsored diagnostic and treatment center providing a comprehensive range of primary health care services and be eligible to receive a medicaid budgeted rate prior to April first of the applicable rate adjustment period after which time, the department shall issue rate adjustments pursuant to this subdivision for such periods. Rate adjustments made pursuant to this subdivision shall be allocated based upon each eligible facility's proportional share of costs for services rendered to uninsured patients which have otherwise not been used for establishing distributions pursuant to subdivision four-a of this section. For the purposes of this subdivision costs shall be measured by multiplying each facility's medicaid budgeted rate by the estimated number of visits reported for services anticipated to be rendered to uninsured patients meeting the aforementioned criteria, less any anticipated patient service revenues received from such uninsured patients, during the applicable rate adjustment period.

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven, seven

million five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight, seven million five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine, fifteen million five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten, seven million five hundred thousand dollars, for the period January first, two thousand eleven through December thirty-first, two thousand eleven, seven million five hundred thousand dollars, for the period January first, two thousand twelve through December thirty-first, two thousand twelve, seven million five hundred thousand dollars, for the period January first, two thousand thirteen through December thirty-first, two thousand thirteen, seven million five hundred thousand dollars, for the period January first, two thousand fourteen through December thirty-first, two thousand fourteen, seven million five hundred thousand dollars, for the period January first, two thousand fifteen through December thirty-first, two thousand fifteen, seven million five hundred thousand dollars, for the period January first two thousand sixteen through December thirty-first, two thousand sixteen, seven million five hundred thousand dollars, for the period January first, two thousand seventeen through December thirty-first, two thousand seventeen, seven million five hundred thousand dollars, for the period January first, two thousand eighteen through December thirty-first, two thousand eighteen, seven million five hundred thousand dollars, for the period January first, two thousand nineteen through December thirty-first, two thousand nineteen, seven million five hundred thousand dollars, for the period January first, two thousand twenty through December thirty-first, two thousand twenty, seven million five hundred thousand dollars, for the period January first, two thousand twenty-one through December thirty-first, two thousand twenty-one, seven million five hundred thousand dollars, for the period January first, two thousand twenty-two through December thirty-first, two thousand twenty-two, seven million five hundred thousand dollars, for the period January first, two thousand twenty-three through December thirty-first, two thousand twenty-three, seven million five hundred thousand dollars, for the period January first, two thousand twenty-four through December thirty-first, two thousand twenty-four, seven million five hundred

thousand dollars, for the period January first, two thousand twenty-five through December thirty-first, two thousand twenty-five, seven million five hundred thousand dollars, for the period January first, two thousand twenty-six through December thirty-first, two thousand twenty-six, seven million five hundred thousand dollars, for the period January first, two thousand twenty-seven through December thirty-first, two thousand twenty-seven, seven million five hundred thousand dollars, for the period January first, two thousand twenty-eight through December thirty-first, two thousand twenty-eight, seven million five hundred thousand dollars, and for the period January first, two thousand twenty-nine through March thirty-first, two thousand twenty-nine, in the amount of one million six hundred thousand dollars, provided, however, that for periods on and after January first, two thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

5. Diagnostic and treatment centers shall furnish to the department such reports and information as may be required by the commissioner to

assess the cost, quality, access to, effectiveness and efficiency of uncompensated care provided. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable diagnostic and treatment centers to fairly and accurately determine and report uncompensated care visits and the costs of uncompensated care. In order to be eligible for an allocation of funds pursuant to this section, a diagnostic and treatment center must be in compliance with uncompensated care reporting requirements.

6. Notwithstanding any inconsistent provision of law to the contrary, the availability or payment of funds to a diagnostic and treatment center pursuant to this section shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for services provided by a diagnostic and treatment center.

7. Revenue from distributions to a diagnostic and treatment center pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

8. (a) For periods on or after January first, two thousand through June thirtieth, two thousand three, payments made to an eligible diagnostic and treatment center pursuant to this section shall be reduced or increased by an amount equal to the amount of any overpayments or underpayments made against grants awarded pursuant to section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven for the period three years prior to the annual awards made pursuant to this section.

(b) The determination of such overpayments or underpayments shall be based on the submission by eligible facilities of reports reflecting actual uncompensated care data, as required by the commissioner, which are attributable to prior periods. Submission of such reports is a condition for an eligible facility's receipt of payments pursuant to this section.

(c) For any periods in which a facility does not receive payments pursuant to this section, the amount of any prior period overpayment may be offset against payments for medical assistance made to such facility pursuant to title eleven of article five of the social services law and credited to funds allocated pursuant to this section. Any prior period underpayment to an eligible facility may be paid to such facility in a subsequent period.

9. Adjustments to rates of payment made pursuant to this section may be added to rates of payment or made as aggregate payments to eligible diagnostic and treatment centers and shall not be subject to subsequent adjustment or reconciliation, provided, however, that in the event such adjustments are made as aggregate payments, then notwithstanding any law, rule or regulation to the contrary responsibility for the local share of such aggregate payments shall be apportioned to a local social services district based on the most recent geographic utilization data available to the department for eligible diagnostic and treatment center services for payments in accordance with subdivisions four-a and four-b of this section for all diagnostic and treatment center services provided in accordance with section three hundred sixty-five-a of the social services law, regardless of whether another social services district or the department may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

10. (a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law, the commissioner is authorized to seek a waiver from the federal department of health and human services pursuant to section eleven hundred fifteen of the federal social security act, or such other federal law provision as may be deemed appropriate, seeking federal financial participation in payments made pursuant to this section, in which case the state funding made available pursuant to this section shall be utilized as the non-federal share of such payments. To the extent as may be required, payments made pursuant to this section and in accordance with this subdivision, may be deemed to be disproportionate share hospital payments in accordance with the provisions of the federal social security act.

(b) If federal financial participation in payments made pursuant to

this section are made available in accordance with the provisions of this subdivision, free-standing clinics licensed solely pursuant to article thirty-one of the mental hygiene law shall also be deemed eligible for participation in such payments to the same degree and in accordance with the same distribution methodology otherwise provided in this section, provided, however, that only those units of service provided by such free-standing clinics that constitute medical services that are otherwise eligible for consideration for Medicaid payments shall be reflected in distributions made pursuant to this section, and further provided, however, that the commissioner may, in consultation with the commissioner of the office of mental health, require such clinics, as a condition of receiving such distributions, to provide reports and data to the department as the commissioner deems necessary to adequately implement the provisions of this subdivision with regard to such clinics.

§ 2807-r. Funding for expansion of cancer services. To the extent of funds available therefor pursuant to section twenty-eight hundred seven-l of this article, the commissioner may allocate funds for competitive grants or reimbursement for the expansion of cancer services into medically underserved or high need areas or medically underserved populations, and for training programs for physicians and other practitioners from medically underserved areas to upgrade their training and education in relation to providing cancer education, detection and treatment services in such areas.

*** § 2807-s. Professional education pool funding.** 1. (a) Payments to general hospitals by all specified third-party payors, as defined in paragraph (b) of subdivision one-a of this section, making payments on a rate, charge, negotiated payment, or other basis for inpatient hospital services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) or eligible for medical assistance pursuant to title eleven of article five of the social services law (including enrollees in medicaid managed care programs) or eligible for the family health plus

program pursuant to title eleven-D of article five of the social services law, and related payments of patient deductible and coinsurance amounts and of secondary third-party payors, shall include a surcharge for a regional allowance on inpatient hospital net patient service revenues in the percentage amount and for the periods specified in subdivision two of this section. Any such allowance shall be submitted by general hospitals to the commissioner or the commissioner's designee in accordance with subdivision five of this section.

(b) The allowance established pursuant to this section shall not be applicable to specified third-party payors filing an election and making payments to the commissioner or the commissioner's designee in accordance with section twenty-eight hundred-seven-t of this article and pursuant to paragraph (a) of subdivision five of section twenty-eight hundred seven-j of this article, nor to related payments of patient deductible and coinsurance amounts and of secondary third-party payors.

1-a. Definitions. (a) "Third-party coverage", for purposes of this section and section twenty-eight hundred seven-t of this article, shall include payments by a specified third-party payor making payments on behalf of a patient; whether made directly to a general hospital or indirectly as indemnity or similar payments made to the patient (or patient's representative such as parent or family member) for inpatient hospital services provided by a general hospital, or through the use of payments made payable to both the general hospital and the patient or patient's representative, or similar devices.

(b) "Specified third-party payors", for purposes of this section and sections twenty-eight hundred seven-j and twenty-eight hundred seven-t of this article, shall include corporations organized and operating in accordance with article forty-three of the insurance law, organizations operating in accordance with the provisions of article forty-four of this chapter, self-insured funds and administrators acting on behalf of self-insured funds, and commercial insurers authorized to write accident and health insurance and whose policy provides coverage on an expense incurred basis. Specified third-party payors, for purposes of this section, shall not include governmental agencies or providers of coverage pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer

firefighters' benefit law, or the volunteer ambulance workers' benefit law.

(c) "Regions", for purposes of this section and section twenty-eight hundred seven-t of this article shall mean the regions as defined in paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six.

2. (a) The regional percentage allowance for any period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine for all general hospitals in the region applicable to a specified third-party payor, and applicable to related patient coinsurance and deductible amounts and to secondary third-party payors under coordination of benefits principles, shall be the following, and shall be applied to inpatient hospital net patient service revenues:

(b) the result expressed as a percentage of:

(i) for each region, the amount allocated to the region in accordance with subdivision six of this section, divided by

(ii) the total estimated nineteen hundred ninety-six general hospital inpatient revenue of all general hospitals in the region, excluding (A) an estimate of revenue from services provided to beneficiaries of title XVIII of the federal social security act (medicare), (B) an estimate of revenue from services provided to patients eligible for payments by governmental agencies, patients eligible for payments pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, and the volunteer ambulance workers' benefit law, and self-pay patients, (C) from general hospitals providing graduate medical education in the aggregate an amount equal to the amount specified in subparagraph (i) of this subdivision, other than the components of such amount allocable to payors specified in clause (B) of this subparagraph, and (D) an estimate of revenue reductions related to negotiated reimbursement in nineteen hundred ninety-seven with specified third-party payors which shall be a uniform statewide percentage estimated reduction.

(c) (i) The regional percentage allowance for the periods January first, two thousand through June thirtieth, two thousand three, for all

general hospitals in the region applicable to specified third-party payors, and applicable to related patient coinsurance and deductible amounts, shall be the same regional percentage allowance calculated pursuant to paragraph (b) of this subdivision for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine.

(ii) The regional percentage allowance for the periods July first, two thousand three through December thirty-first, two thousand five, for all general hospitals in the region applicable to specified third-party payors, and applicable to related patient coinsurance and deductible amounts, shall be the same regional percentage allowance calculated pursuant to paragraph (b) of this subdivision for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine multiplied by one hundred eight and nineteen hundredths percent.

(iii) The regional percentage allowance for the periods January first, two thousand six through June thirtieth, two thousand seven, for all general hospitals in the region applicable to specified third-party payors, and applicable to related patient coinsurance and deductible amounts, shall be the same regional percentage allowance calculated pursuant to subparagraph (ii) of this paragraph for the period January first, two thousand five through December thirty-first, two thousand five multiplied by one hundred one and thirteen hundredths percent.

(iv) The regional percentage allowance for periods on and after July first, two thousand seven, for all general hospitals in the region applicable to specified third-party payors, and applicable to related patient coinsurance and deductible amounts, shall be the same regional percentage allowance calculated pursuant to subparagraph (iii) of this paragraph for the period January first, two thousand six through June thirtieth, two thousand seven.

3. Inpatient hospital net patient service revenues, for purposes of this section, shall mean for general hospitals all moneys received for or on account of inpatient hospital services provided to persons with third-party coverage from a specified third-party payor, including capitation payments allocable to inpatient hospital services, less refunds, for patients discharged or contracted hospital inpatient

service obligations for periods on or after January first, nineteen hundred ninety-seven excluding the following subject to the provisions of subdivision eight of this section:

(a) revenue received from the allowances pursuant to section twenty-eight hundred seven-j of this article and this section; and

(b) revenue received from physician practice or faculty practice plan discrete billings for private practicing physician services.

4. (a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the allowances established pursuant to this section and funds from the assessments established pursuant to section twenty-eight hundred seven-t of this article. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis eight hundred fifty thousand dollars for collection and distribution of allowances established pursuant to this section and assessments established pursuant to this section and assessments established pursuant to section twenty-eight hundred seven-t of this article shall be paid from the allowance and assessment funds.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of bad debt and charity care pools for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six pursuant to section twenty-eight hundred seven-c of this article may be extended to provide for administration pursuant to this section, and section twenty-eight hundred seven-t of this article and may be amended as may be necessary.

5. Funds due by a general hospital to the commissioner or the commissioner's designee from the allowance pursuant to this section

shall be due and shall be collected under the terms and conditions provided for payment and collection of allowances pursuant to section twenty-eight hundred seven-j of this article.

6. The amount allocated to each region for purposes of calculating the regional allowance percentage pursuant to this section for each year during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and the regional assessments pursuant to section twenty-eight hundred seven-t of this article for each year during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and for each year on and after January first, two thousand, shall be the sum of the factors computed in paragraphs (b), (d) and (f) of this subdivision, if such factors are applicable to a given year, as follows:

(a) (i) A gross annual statewide amount for nineteen hundred ninety-seven shall be five hundred eighty-nine million dollars.

(ii) A gross annual statewide amount for nineteen hundred ninety-eight shall be five hundred eighty-nine million dollars.

(iii) A gross annual statewide amount for nineteen hundred ninety-nine shall be five hundred eighty-nine million dollars.

(iv) A gross annual statewide amount for two thousand shall be five hundred eighty-nine million dollars.

(v) A gross annual statewide amount for two thousand one shall be five hundred sixty-nine million dollars.

(vi) A gross annual statewide amount for two thousand two shall be five hundred eighty-nine million dollars.

(vii) A gross annual statewide amount for two thousand three shall be five hundred eighty-nine million dollars.

(viii) A gross annual statewide amount for two thousand four and two thousand five shall be six hundred twenty-four million dollars.

(ix) A gross annual statewide amount for two thousand six shall be six hundred seventy-four million dollars.

(x) A gross statewide amount for the period January first, two thousand seven through March thirty-first, two thousand seven shall be one hundred sixty-eight million five hundred thousand dollars, and for the period April first, two thousand seven through December thirty-first, two thousand seven shall be five hundred sixty-one million

seven hundred fifty thousand dollars.

(xi) A gross statewide amount for the period January first, two thousand eight through March thirty-first, two thousand eight, shall be one hundred eighty-seven million two hundred fifty thousand dollars.

(xii) A gross statewide amount for the period April first, two thousand eight through December thirty-first, two thousand eight, shall be five hundred sixty-one million seven hundred fifty thousand dollars.

(xiii) A gross statewide amount for the period October first, two thousand eight through March thirty-first, two thousand nine, shall be one hundred seventy-four million two hundred thousand dollars. Such amount shall be separately reported and paid in six monthly installments by the tenth day of each month from October two thousand eight to March two thousand nine. Such reports and payments must initially be based on each payers' monthly enrollment count for the preceding month and shall be reconciled on a month to month basis to reflect the actual monthly enrollment counts for the applicable month.

(xiv) A gross annual statewide amount for the period January first, two thousand nine through December thirty-first, two thousand fourteen, shall be nine hundred forty-four million dollars.

(xv) A gross annual statewide amount for the period January first, two thousand fifteen through December thirty-first, two thousand twenty-two, shall be one billion forty-five million dollars.

(xvi) A gross annual statewide amount for the period January first, two thousand twenty-three to December thirty-first, two thousand twenty-six shall be one billion eighty-five million dollars, forty million dollars annually of which shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities of and the state of New York based on each municipality's share and the state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

(xvii) A gross annual statewide amount for the period January first, two thousand twenty-seven to December thirty-first, two thousand twenty-nine shall be one billion eighty-five million dollars, forty million dollars annually of which shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities of and the state of New York based on each municipality's share and the

state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

(b) The amount specified in paragraph (a) of this subdivision shall be allocated among the regions based on each region's proportional share of the sum of the estimated revenue of all general hospitals in the region, excluding revenue related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), related to one hundred percent of the direct medical education expenses and fifty-nine and five-tenths percent of indirect medical education expenses reflected in general hospital inpatient revenue compared to the sum of such amounts for all regions, based on estimated nineteen hundred ninety-six data and statistics, excluding an estimate of revenue from services provided to patients eligible for payments by governmental agencies, patients eligible for payments pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, and the volunteer ambulance workers' benefit law, and self-pay patients.

(c) (i) A further gross annual statewide amount for nineteen hundred ninety-seven shall be sixty-four million dollars.

(ii) A further gross annual statewide amount for nineteen hundred ninety-eight shall be sixty-four million dollars.

(iii) A further gross annual statewide amount for nineteen hundred ninety-nine shall be eighty-nine million dollars.

(iv) A further gross annual statewide amount for two thousand, two thousand one, two thousand two, two thousand three, two thousand four, two thousand five, two thousand six, two thousand seven, two thousand eight, two thousand nine, two thousand ten, two thousand eleven, two thousand twelve and two thousand thirteen shall be eighty-nine million dollars.

(v) A further gross annual statewide amount for the period January first, two thousand fourteen through December thirty-first, two thousand fourteen, shall be eighty-nine million dollars.

(d) For each year, the amount specified in paragraph (c) of this subdivision shall be allocated among the regions based on the same regional percentage allocations as determined in accordance with paragraph (b) of this subdivision.

(e) A further gross annual statewide amount shall be twelve million dollars for each period prior to January first, two thousand fifteen.

(f) For each year, the amount specified in paragraph (e) of this subdivision shall be allocated among the regions based on each region's allocated share of the AIDS drug assistance program expenditures for the latest annual period for which such data are available.

(g) A further gross statewide amount for the state fiscal year two thousand twenty-two shall be forty million dollars.

(h) The amount specified in paragraph (g) of this subdivision shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities and the state of New York based on each municipality's share and the state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

7. Funds accumulated, including income from invested funds, from the allowances specified in this section and the assessments pursuant to section twenty-eight hundred seven-t of this article, including interest and penalties, shall be deposited by the commissioner or the commissioner's designee as follows:

(a) funds shall be accumulated in regional professional education pools established by the commissioner or the healthcare reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, for distribution in accordance with section twenty-eight hundred seven-m of this article, in the following amounts:

(i) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) ninety-two and forty-five-hundredths percent of the funds accumulated less one hundred one million dollars for the period January first, nineteen hundred ninety-nine through December thirty-first,

nineteen hundred ninety-nine,

(iv) four hundred ninety-four million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand three,

(v) four hundred sixty-three million dollars for the period January first, two thousand four through December thirty-first, two thousand four,

(vi) four hundred eighty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five,

(vii) four hundred ninety-four million dollars for the period January first, two thousand six through December thirty-first, two thousand six,

(viii) four hundred seventy million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven,

(ix) four hundred forty-six million six hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight,

(x) forty-seven million two hundred ten thousand dollars on an annual basis for the periods January first, two thousand nine through December thirty-first, two thousand ten;

(xi) eleven million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xii) twenty-three million eight hundred thirty-six thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(xiii) twenty-three million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand twenty-nine;

(xiv) provided, however, for periods prior to January first, two thousand nine, amounts set forth in this paragraph may be reduced by the commissioner in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the graduate medical education program established pursuant to section twenty-eight hundred seven-m of this article;

(xv) provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the total actual distribution reductions for all facilities pursuant to paragraph (e) of subdivision three of section twenty-eight hundred seven-m of this article; and

(xvi) provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-m of this article.

(b) funds shall be added to the funds collected by the commissioner for distribution in accordance with section twenty-eight hundred seven-j of this article, in the following amounts:

(i) seven and fifty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) seven and fifty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) seven and fifty-five-hundredths percent of the funds accumulated less one hundred one million dollars for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine,

(iv) the remaining balance of the funds accumulated for each period on and after January first, two thousand; and

(c) further funds shall be added to the funds collected by the commissioner for distribution in accordance with section twenty-eight hundred seven-j of this article:

(i) for the nineteen hundred ninety-seven period, seventy-six million dollars;

(ii) for the nineteen hundred ninety-eight period, seventy-six million dollars; and

(iii) for the nineteen hundred ninety-nine period, one hundred one million dollars.

(d) funds shall be added to the funds collected by the commissioner

for distribution in accordance with section twenty-eight hundred seven-o of this article, in the following amount: forty million dollars for the period beginning April first, two thousand twenty-two, and continuing each state fiscal year thereafter.

8. Each exclusion from the allowances effective on or after January first, nineteen hundred ninety-seven established pursuant to this section shall be contingent upon either: (a) qualification of the allowances for waiver pursuant to federal law and regulation; or (b) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the allowances under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the allowances not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the allowances relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the allowances do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of January first, nineteen hundred ninety-seven, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the general hospital pays the retroactive amount due within ninety days of notice from the commissioner to the general hospital that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner or the commissioner's designee to the general hospital.

9. Revenue from the allowances pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve

of section twenty-eight hundred seven-d of this article.

* NB Expires December 31, 2029

*** § 2807-t. Assessments on covered lives. 1. Definitions. (a)**

"Individual" means a person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services in the period other than:

(i) any person who is eligible for payments as a beneficiary of title XVIII of the federal social security act (medicare);

(ii) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services contingent upon such person's relationship to an "individual" as a spouse, child, stepchild, adopted child, family member, or dependent, as defined by the specified third-party payor, or as contingent upon any other similar relationship to an "individual" as such relationship is defined by the specified third-party payor;

(iii) any person for whom the specified third-party payor has agreed to provide coverage for hospital confinement on other than an expense incurred basis;

(iv) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law;

(v) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services pursuant to the comprehensive motor vehicle insurance reparations act;

(vi) any person (hereinafter referred to as the "primary insured") otherwise meeting the definition of an "individual" as set forth under this section if the specified third-party payor has agreed to provide reimbursement for such person as part of a "family unit"; and

(vii) effective on and after April first, two thousand five, any person covered under a student policy issued pursuant to article forty-three of the insurance law, or a blanket student accident, blanket student health, or blanket student accident and health insurance policy.

(b) "Family unit" means any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital

services in the period, together with one or more additional persons for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services in the period contingent upon such person's relationship to said person as a spouse, child, stepchild, adopted child, family member, or dependent, as defined by the specified third-party payor, or as contingent upon any other similar relationship, as such relationship is defined by the specified third-party payor. Excluded from the definition is any family unit where the specified third-party payor has agreed to provide: coverage for hospital confinement on other than an expense incurred basis; reimbursement for inpatient hospital services pursuant to the worker's compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law; and reimbursement for inpatient hospital services pursuant to the comprehensive motor vehicle insurance reparations act. If a family unit of two persons includes one person who is eligible for payments as a beneficiary of title XVIII of the social security act (medicare), that family unit shall be deemed an individual for purposes of this section. If a family unit of three or more persons includes one person who is not eligible for medicare and the remaining two or more persons are eligible for medicare, that family unit shall be deemed an individual for purposes of this section. A family unit of two or more persons, all of whom are eligible for medicare, shall not be considered a family unit or an individual for purposes of this section.

(c) "Specified third-party payor", for purposes of this section, shall have the same meaning as set forth in section twenty-eight hundred seven-s of this article.

(d) "Region", for purposes of this section, shall have the same meaning as set forth in section twenty-eight hundred seven-s of this article.

2. Determination of annual regional payment amount. The sum total to be generated each year for each region shall be referred to as the annual regional payment amount, as determined in accordance with subdivision six of section twenty-eight hundred seven-s of this article.

3. Election. Any specified third-party payor may make an election to make payments for the assessments required by this section, on behalf of

the liable persons or entities pursuant to subdivision eight of this section, directly to the commissioner or the commissioner's designee. The election pursuant to this subdivision must be in writing, filed with the commissioner or the commissioner's designee on such forms and in such manner as the commissioner shall require. An election by a specified third-party payor shall take effect for nineteen hundred ninety-seven on the next following January first, April first, July first, or October first not less than thirty days after the election is filed. Beginning December first, nineteen hundred ninety-seven, an election pursuant to this section must be made no later than December first of the year prior to the assessment year. However, any specified third-party payor licensed pursuant to the insurance law or certified pursuant to article forty-four of this chapter between December first of the year prior to the assessment year and December thirty-first of the assessment year may make an election subsequent to such licensure or certification and during said time period, to take effect on the next following January first, April first, July first or October first not less than thirty days after such election is filed. Specified third-party payors other than those licensed pursuant to the insurance law or certified pursuant to this chapter which have not provided coverage prior to December first of the year prior to the assessment year may make an election at any time from December first of the year prior to said assessment year to December thirty-first of said assessment year, to take effect on the next following January first, April first, July first or October first not less than thirty days after the election is filed. An election shall remain in effect unless revoked in writing by a specified third-party payor, which revocation shall be effective on the first day of the next calendar year quarter, provided that such payor has provided notice of its intention to so revoke at least thirty days prior to the beginning of such calendar quarter.

(a) A specified third-party payor filing an election pursuant to this subdivision must agree: to provide the data and information required by subdivision four of this section; to provide such certification of data and access to individual and family unit data for audit verification purposes as the commissioner shall require for purposes of this section; and to the jurisdiction of the state to maintain an action in the courts of the state of New York to enforce any provision of this section

related to payment of the assessments.

(b) If a specified third-party payor is acting in an administrative services capacity on behalf of an organization, such as a self-insured fund, the consent of the organization to the election and the conditions pursuant to paragraph (a) of this subdivision must be submitted with the election. Such consent may be set forth in writing in the agreement between the specified third-party payor and the organization.

(c) If a specified third-party payor, including a payor operating in accordance with the insurance law or article forty-four of this chapter, making an election pursuant to this subdivision is acting in an administrative services capacity on behalf of an organization or organizations, such specified third-party payor must specify (i) whether such election applies to payments on behalf of all such organizations, and (ii) identify any organizations for which such specified third-party payor is acting to which the election does not apply and establish, in accordance with guidelines established by the superintendent of financial services, a system through which general hospitals and the commissioner can identify the status of a patient as a patient for whom the election does not apply.

(d) The commissioner may deny a specified third-party payor the opportunity to make an election pursuant to this subdivision based on repeated late payments, failure to remit correct amounts, or failure to provide adequate verification of the accuracy of payments.

(e) The commissioner or the commissioner's designee shall make available to all general hospitals a list of the specified third-party payors which have elected pursuant to this subdivision to remit payments pursuant to this section.

4. Assessments shall be calculated as follows: (a) Every specified third-party payor that has made an election pursuant to this section shall report to the commissioner or the commissioner's designee the number of individuals for a period as determined by the commissioner during the calendar year prior to the assessment year residing within each region ("individual member months"). Every such specified third-party payor shall also report to the commissioner or the commissioner's designee the number of family units for a period as determined by the commissioner during the calendar year prior to the

assessment year residing within each region ("family member months"). For purposes of this section, the family unit is considered to reside in the region in which the primary insured resides.

(b) The superintendent of financial services shall advise the commissioner of the average number of persons covered under family insurance contracts providing health care coverage approved by the superintendent for the year two years prior to the assessment year.

(c) The commissioner shall calculate the total number of "individual member months" for each region for all specified third-party payors to determine "aggregate individual member months" for each region.

(d) The commissioner shall calculate the total number of "family member months" for each region for all specified third-party payors to determine "aggregate family member months" for each region. The commissioner shall multiply the average number of persons covered under family insurance contracts, as reported to the commissioner by the superintendent of financial services, by the "aggregate family member months" to determine "adjusted aggregate family member months" for each region. The commissioner shall add the number of "adjusted aggregate family member months" for each region to the total number of "aggregate individual member months" for each region. This amount shall be known as "total covered member months" for each region.

(e) The annual regional payment amount for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively for each region determined pursuant to subdivision two of this section shall be divided by an estimate derived from population based data sources of the total covered member months determined consistent with the provisions of paragraphs (a), (b), (c) and (d) of this subdivision in that region to establish the individual annual assessment for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively. The individual annual assessment shall be multiplied by the average family size reported to the commissioner by the superintendent of financial services to establish the family unit annual assessment in that region for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively.

(f) Effective January first, two thousand nine, a specified third-party payor that has made an election pursuant to this section may report to the commissioner or the commissioner's designee the number of individuals and family units enrolled as of the last day of each month in fulfillment of the monthly reporting requirement set forth in paragraph (a) of this subdivision. A specified third-party payor choosing to report monthly enrollment counts on this basis shall indicate its choice at the beginning of a calendar year in a form and manner specified by the commissioner and such reporting method shall remain in effect the entire calendar year.

5. Monthly payments. (a) Within thirty days after the end of each month, a specified third-party payor which made an election pursuant to this section shall remit to the commissioner or the commissioner's designee one-twelfth of the individual annual assessment for each of the individuals residing in this state which were included on the membership rolls of that specified third-party payor during all or any portion of the prior month. Within thirty days after the end of each month, a specified third-party payor which made an election pursuant to this section shall also remit to the commissioner or the commissioner's designee one-twelfth of the family unit annual assessment for each family unit for which the primary insured resided in this state which were included on the membership rolls of that specified third-party payor during all or any portion of the prior month. Provided, however, for assessment obligations arising out of individual and family assessments established pursuant to this section on or after January first, two thousand, the commissioner may permit certain specified third-party payors which have at least one full year of pool payment experience to submit such payments on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-j and twenty-eight hundred seven-s of this article are not expected to exceed ten thousand dollars in the current pool year. If a specified third-party payor fails to make such payments within sixty days of notification of a delinquency, the commissioner may assess a civil penalty of up to ten thousand dollars for each failure, provided, however, that such civil penalty shall not be imposed if the

payor demonstrates good cause for such failure to timely make such payments, and further provided that the amount of such penalty shall not exceed the amount of the delinquent liability.

(b) The specified third party-payor shall be entitled to rely on the residence location information provided to the payor by an employer, group or other party providing enrollment information to the specified third-party payor, provided the specified third-party payor has no reason to doubt the accuracy of the information.

(c) Specified third-party payors shall not be responsible for remitting the monthly assessment for any individual or for any family unit for any month in which it is subsequently determined that the specified third-party payor had no liability to provide coverage for inpatient hospital services for such individual or family unit.

6. Prospective adjustments. (a) The commissioner shall annually reconcile the sum of the actual payments made to the commissioner or the commissioner's designee for each region pursuant to section twenty-eight hundred seven-s of this article and pursuant to this section for the prior year with the regional allocation of the gross annual statewide amount specified in subdivision six of section twenty-eight hundred seven-s of this article for such prior year. The difference between the actual amount raised for a region and the regional allocation of the specified gross annual amount for such prior year shall be applied as a prospective adjustment to the regional allocation of the specified gross annual payment amount for such region for the year next following the calculation of the reconciliation. The authorized dollar value of the adjustments shall be the same as if calculated retrospectively.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, for covered lives assessment rate periods on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-one, for amounts collected in the aggregate in excess of one billion forty-five million dollars on an annual basis, and for the period January first, two thousand twenty-two to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, prospective adjustments shall be suspended if the annual reconciliation calculation from the prior year would otherwise result in a decrease to

the regional allocation of the specified gross annual payment amount for that region, provided, however, that such suspension shall be lifted upon a determination by the commissioner, in consultation with the director of the budget, that sixty-five million dollars in aggregate collections on an annual basis over and above one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-one and for the period January first, two thousand twenty-two to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis have been reserved and set aside for deposit in the HCRA resources fund. Any amounts collected in the aggregate at or below one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-two, and for the period January first, two thousand twenty-three to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, shall be subject to regional adjustments reconciling any decreases or increases to the regional allocation in accordance with paragraph (a) of this subdivision.

7. (a) In the case two or more specified third-party payors covering a single contract holder where both specified third-party payors cover separate components of the inpatient care benefits otherwise subject to the assessment, the assessment shall be apportioned between the insurers.

(b) With regard to assessment obligations arising out of individual and family assessments established pursuant to this section, where a single contract holder has separate components of the inpatient care benefits otherwise subject to the assessment covered by two or more entities, the assessment may be apportioned between the entities, provided that:

(i) Apportionment agreements or arrangements may only be entered into between or among specified third-party payers which have elected to make direct payments to the commissioner or the commissioner's designee pursuant to this subdivision; and

(ii) The aggregate of apportioned covered lives assessment payments must result in the payment of one hundred percent of the applicable covered lives assessment; and

(iii) Apportionment agreements between or among apportioning payers and any modifications, amendments or termination of such agreements must be in writing and signed by all such payers, provided, however, that where one apportioning payor agrees to pay one hundred percent of the applicable covered lives assessment, no written agreement shall be required, provided there is other written evidence of the arrangement and any modifications, amendments and/or terminations thereof, emanating from the apportioning payor paying one hundred percent of the applicable covered lives assessment to the other apportioning payor or payors or to the particular group to which the arrangement relates, and further provided that such written evidence contains the name of the particular group to which the arrangement relates; and

(iv) Copies of apportionment agreements, and any modifications, amendments and/or terminations thereof, and written evidence of arrangements by which one apportioning payor agrees to pay one hundred percent of the applicable covered lives assessment, and any modifications, amendments and/or terminations thereof, must be maintained in the files of each apportioning payor while the apportionment is in effect and for a period of not less than six years after termination thereof and shall be made available to the department upon request for audit verification purposes.

8. Liability for assessments. (a) The assessments determined in accordance with this section shall, for individuals who have paid premiums directly to an insurer or to a health maintenance organization certified pursuant to article forty-four of this chapter or article forty-three of the insurance law for health care coverage which includes coverage of inpatient hospital services, be the liability of said individuals. The assessments determined in accordance with this section shall, for groups and entities who have paid premiums to an insurer or to a health maintenance organization certified pursuant to article forty-four of this chapter or article forty-three of the insurance law for health care coverage which includes coverage of inpatient hospital services, be the liability of said groups and entities. The assessments

determined in accordance with this section shall, for individuals, groups and entities who have contributed to a self-insured fund for health care coverage which includes coverage of inpatient hospital services, be the liability of said individuals, groups or entities.

(b) Specified third-party payors shall make payments to the commissioner or the commissioner's designee of the full amount of the assessments determined in accordance with this section. Specified third-party payors may recover amounts due or paid to the commissioner or the commissioner's designee from the parties liable in accordance with paragraph (a) of this subdivision.

9. A specified third-party payor must either:

(a) jointly elect to pay the assessment pursuant to this section and the allowance pursuant to paragraph (c) of subdivision two and subdivision five of section twenty-eight hundred seven-j of this article; or

(b) pay the surcharge for an allowance determined in accordance with paragraph (b) of subdivision two of section twenty-eight hundred seven-j of this article, including the allowance determined in accordance with section twenty-eight hundred seven-s of this article.

10. (a) Payments and reports submitted or required to be submitted to the commissioner or to the commissioner's designee pursuant to this section by specified third-party payors shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by such specified third-party payors with regard to subsequent payments, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year period, or from conducting an audit of any adjustments and reconciliation made by a specified third party payor within such six year period, or from conducting an audit of payments made prior to such six year period which are found to be commingled with

payments which are otherwise subject to timely audit pursuant to this section.

(b) Specified third-party payors which, in the course of an audit pursuant to this section fail to produce data or documentation requested in furtherance of such an audit, within thirty days of such request, may be assessed a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if such specified third-party payor demonstrates good cause for such failure. The imposition of civil penalties pursuant to this section shall be subject to the provisions of section twelve-a of this chapter.

(c) Records required to be retained for audit verification purposes by specified third-party payors in accordance with this section shall include, but not be limited to, on a monthly basis, the source records generated by supporting information systems, financial accounting records, relevant correspondence and the addresses and dates of coverage for all individuals and family units, as defined by paragraphs (a) and (b) of subdivision one of this section, and such other records as may be required to prove compliance with, and to support reports submitted in accordance with, this section.

(d) If a specified third-party payor fails to produce data or documentation requested in furtherance of an audit pursuant to this section for a month to which an assessment applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of the enrollment exemptions permitted pursuant to this section cannot be determined from such available financial and statistical data, the estimated amount due may be calculated on the basis of aggregate data derived from such available data for the year subject to audit. The commissioner shall take all necessary steps to collect amounts due as determined pursuant to this paragraph, including directing the state comptroller to offset such amounts due from any payments made by the state to the third party payor pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of subdivision eight of section twenty-eight hundred seven-j of this article.

(e) The commissioner may, as part of a final resolution of an audit conducted pursuant to this subdivision, waive payment of interest and

penalties otherwise applicable pursuant to subdivision eight of section twenty-eight hundred seven-j of this article, when amounts due as a result of such audit, other than such waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of the issuance of a final audit report that is mutually agreed to by the commissioner and auditee, provided, however, that if such final audit report is not so mutually agreed upon, then neither the commissioner nor the auditee shall have any obligations pursuant to this paragraph.

(f) The commissioner may enter into agreements with specified third-party payors in regard to which audit findings or prior settlements have been made pursuant to this section, extending and applying such audit findings or prior settlements, or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable to such subsequent unaudited periods when such amounts due as a result of such agreement, other than reduced or waived interest and penalties, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this section, as referenced in such agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by payors subsequent to such agreements.

* NB Expires December 31, 2029

§ 2807-u. Transfers for tax credits. Upon receipt of the report from the commissioner of taxation and finance required pursuant to subdivision (i) of section fifteen hundred eleven of the tax law and the report from the superintendent of financial services required pursuant to section one thousand one hundred twelve-a of the insurance law, the director of the budget shall forward such reports to the commissioner of health. Within ten days of receipt of such reports, the commissioner of

health or the commissioner of health's designee, from funds allocated for distribution in accordance with paragraphs (a) and (c) of subdivision seven of section twenty-eight hundred seven-s of this article, shall pay over to the state comptroller for deposit into the state's general fund the amounts specified therein as representing (1) the amount of credits claimed under subdivision (i) of section fifteen hundred eleven of the tax law and (2) the amount by which taxes due and owing pursuant to section one thousand one hundred twelve of the insurance law were reduced because the amounts imposed and required to be paid pursuant to section twenty-eight hundred seven-t of this article were allowed as credits in assessing the taxes imposed by such section one thousand one hundred twelve.

§ 2807-v. Tobacco control and insurance initiatives pool distributions. 1. Funds accumulated in the tobacco control and insurance initiatives pool or in the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following:

(a) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of services and expenses related to the toll-free medicaid fraud hotline established pursuant to section one hundred eight of chapter one of the laws of nineteen hundred ninety-nine from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: four hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred thousand dollars for the period January first, two thousand four through December

thirty-first, two thousand four, up to four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to four hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to four hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to four hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and within amounts appropriated on and after April first, two thousand eleven.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of payment of audits or audit contracts necessary to determine payor and provider compliance with requirements set forth in sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five million six hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to seven million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and up to eight million three hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to eight

million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fourteen million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(c) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, enhanced community services account, or any successor fund or account, for mental health services programs for case management services for adults and children; supported housing; home and community based waiver services; family based treatment; family support services; mobile mental health teams; transitional housing; and community oversight, established pursuant to articles seven and forty-one of the mental hygiene law and subdivision nine of section three hundred sixty-six of the social services law; and for comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred

from the enhanced community services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law; from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) forty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand, for the period January first, two thousand through December thirty-first, two thousand;

(ii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand one, for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand two, for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand three, for the period January first, two thousand three through December thirty-first, two thousand three;

(v) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand four, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand five, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand six, and pursuant to former section twenty-seven hundred ninety-nine-l of this chapter, for the

period January first, two thousand six through December thirty-first, two thousand six;

(viii) eighty-six million four hundred thousand dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand seven and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) twenty-two million nine hundred thirteen thousand dollars, plus one hundred twenty-five thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand eight and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand eight through March thirty-first, two thousand eight.

(d) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two, for administration and marketing costs associated with such program established pursuant to clause (A) of subparagraph (v) of paragraph (a) of subdivision two of former section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-seven million dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) fifty-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(e) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account,

or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two for administration and marketing costs associated with such program established pursuant to clause (B) of subparagraph (v) of paragraph (a) of subdivision two of former section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) thirty million five hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) sixty-six million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(f) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of payment of administrative expenses of the department related to the family health plus program established pursuant to former section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five hundred thousand dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand six, five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and

within amounts appropriated on and after April first, two thousand eleven.

(g) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the health maintenance organization direct pay market program established pursuant to sections four thousand three hundred twenty-one-a and four thousand three hundred twenty-two-a of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-five million dollars for the period January first, two thousand through December thirty-first, two thousand of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(ii) up to thirty-six million dollars for the period January first, two thousand one through December thirty-first, two thousand one of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iii) up to thirty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iv) up to forty million dollars for the period January first, two thousand three through December thirty-first, two thousand three of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(v) up to forty million dollars for the period January first, two thousand four through December thirty-first, two thousand four of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty

percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vi) up to forty million dollars for the period January first, two thousand five through December thirty-first, two thousand five of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vii) up to forty million dollars for the period January first, two thousand six through December thirty-first, two thousand six of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(viii) up to forty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law; and

(ix) up to forty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight of which fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law.

(h) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York individual program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to six million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to twenty-nine million dollars for the period January first,

two thousand two through December thirty-first, two thousand two;

(iii) up to five million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York group program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to seventy-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iii) up to ten million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the

period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

* (i-1) Notwithstanding the provisions of paragraphs (h) and (i) of this subdivision, the commissioner shall reserve and accumulate up to two million five hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, one million four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, from funds otherwise available for distribution under such paragraphs for the services and expenses related to the pilot program for entertainment industry employees included in subsection (b) of section one thousand one hundred twenty-two of the insurance law, and an additional seven hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, an additional three hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven for services and expenses related to the pilot program for displaced workers included in subsection (c) of section one thousand one hundred twenty-two of the insurance law.

* NB Repealed July 1, 2027

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the tobacco use prevention and control program established pursuant to sections thirteen hundred ninety-nine-ii and thirteen hundred ninety-nine-jj of this chapter, from the tobacco control and insurance initiatives pool established for the

following periods in the following amounts:

(i) up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to forty million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to forty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to eighty-one million nine hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(viii) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(ix) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) up to eighty-seven million seven hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) up to twenty-one million four hundred twelve thousand dollars

for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) up to fifty-two million one hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xiv) up to six million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xv) up to six million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xvi) up to six million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xvii) up to six million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xviii) up to six million dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(k) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes of services and expenses related to public health programs, including comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the health care services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law for periods prior to March thirty-first, two thousand eleven, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-one million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to eighty-one million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) one hundred twenty-two million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) one hundred eight million five hundred seventy-five thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) ninety-one million eight hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) one hundred fifty-six million six hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) one hundred fifty-one million four hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) twenty-nine million two hundred thirty-seven thousand two hundred fifty dollars, plus an additional one hundred twenty-five thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred twenty million thirty-eight thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve; and

(xiv) one hundred nineteen million four hundred seven thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen.

(l) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the personal care and certified home health agency rate or fee increases established pursuant to subdivision three of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-three million two hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-three million two hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) twenty-three million two hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to sixty-five million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to sixty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to sixty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to sixty-five million two hundred thousand dollars for the

period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to sixteen million three hundred thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(m) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to home care workers insurance pilot demonstration programs established pursuant to subdivision two of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million eight hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) three million eight hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to three million eight hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to three million eight hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to three million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to three million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to three million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first,

two thousand seven; and

(ix) up to nine hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(n) Funds shall be transferred by the commissioner and shall be deposited to the credit of the special revenue funds - other, miscellaneous special revenue fund - 339, elderly pharmaceutical insurance coverage program premium account authorized pursuant to the provisions of title three of article two of the elder law, or any successor fund or account, for funding state expenses relating to the program from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one hundred seven million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) one hundred sixty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three hundred twenty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) four hundred thirty-three million three hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) five hundred four million one hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) five hundred sixty-six million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) six hundred three million one hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) six hundred sixty million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) three hundred sixty-seven million four hundred sixty-three thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) three hundred thirty-four million eight hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) three hundred forty-four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) eighty-seven million seven hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred forty-three million one hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(xiv) one hundred twenty million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(xv) one hundred twenty-eight million eight hundred fifty thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen;

(xvi) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xvii) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xviii) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xix) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xx) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(o) Funds shall be reserved and accumulated and shall be transferred to the Roswell Park Cancer Institute Corporation, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

- (i) up to ninety million dollars for the period January first, two thousand through December thirty-first, two thousand;
- (ii) up to sixty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;
- (iii) up to eighty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;
- (iv) eighty-five million two hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;
- (v) seventy-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;
- (vi) seventy-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
- (vii) ninety-one million dollars for the period January first, two thousand six through December thirty-first, two thousand six;
- (viii) seventy-eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
- (ix) seventy-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
- (x) seventy-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
- (xi) seventy-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;
- (xii) nineteen million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;
- (xiii) sixty-nine million eight hundred forty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;
- (xiv) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;
- (xv) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;
- (xvi) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through

March thirty-first, two thousand twenty-three;

(xvii) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xviii) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(p) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, indigent care fund - 068, indigent care account, or any successor fund or account, for purposes of providing a medicaid disproportionate share payment from the high need indigent care adjustment pool established pursuant to section twenty-eight hundred seven-w of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two;

(ii) up to eighty-two million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to eighty-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eighty-two million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eighty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to eighty-two million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to eighty-two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to eighty-two million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to eighty-two million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to twenty million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two

thousand eleven; and

(xi) up to eighty-two million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(q) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing distributions to eligible school based health centers established pursuant to section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million dollars annually for the period January first, two thousand through December thirty-first, two thousand two;

(ii) up to seven million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to seven million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to seven million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to seven million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to seven million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to seven million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to seven million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to one million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to five million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand fourteen

through March thirty-first, two thousand seventeen;

(xiii) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(r) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions for supplementary medical insurance for Medicare part B premiums, physicians services, outpatient services, medical equipment, supplies and other health services, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) forty-three million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) sixty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) sixty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) sixty-seven million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) sixty-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) sixty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) sixty-eight million dollars for the period January first, two

thousand six through December thirty-first, two thousand six;

(viii) seventeen million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) sixty-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) sixty-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) sixty-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) seventeen million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xiii) sixty-eight million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(s) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions pursuant to paragraphs (s-5), (s-6), (s-7) and (s-8) of subdivision eleven of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-four million dollars annually for the periods January first, two thousand one through December thirty-first, two thousand two;

(iii) up to twenty-four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to twenty-four million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to twenty-four million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to twenty-four million dollars for the period January first,

two thousand seven through December thirty-first, two thousand seven;

(viii) up to twenty-four million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(ix) up to twenty-two million dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(t) Funds shall be reserved and accumulated from year to year by the commissioner and shall be made available, including income from invested funds:

(i) For the purpose of making grants to a state owned and operated medical school which does not have a state owned and operated hospital on site and available for teaching purposes. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, such grants shall be made in the amount of up to five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) For the purpose of making grants to medical schools pursuant to section eighty-six-a of chapter one of the laws of nineteen hundred ninety-nine in the sum of up to four million dollars for the period January first, two thousand through December thirty-first, two thousand; and

(iii) The funds disbursed pursuant to subparagraphs (i) and (ii) of this paragraph from the tobacco control and insurance initiatives pool are contingent upon meeting all funding amounts established pursuant to paragraphs (a), (b), (c), (d), (e), (f), (l), (m), (n), (p), (q), (r) and (s) of this subdivision, paragraph (a) of subdivision nine of section twenty-eight hundred seven-j of this article, and paragraphs (a), (i) and (k) of subdivision one of section twenty-eight hundred seven-l of this article.

(u) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the nursing home quality improvement demonstration program established pursuant to section twenty-eight hundred eight-d of this article from the tobacco control

and insurance initiatives pool established for the following periods in the following amounts:

(i) up to twenty-five million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two, and on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand four;

(ii) up to eighteen million seven hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(iii) up to fifty-six million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(v) Funds shall be transferred by the commissioner and shall be deposited to the credit of the hospital excess liability pool created pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, or any successor fund or account, for purposes of expenses related to the purchase of excess medical malpractice insurance and the cost of administering the pool, including costs associated with the risk management program established pursuant to section forty-two of part A of chapter one of the laws of two thousand two required by paragraph (a) of subdivision one of section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as may be amended from time to time, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty million dollars or so much as is needed for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to seventy-six million seven hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to sixty-five million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to sixty-five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to one hundred thirteen million eight hundred thousand dollars

for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to one hundred thirty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to one hundred thirty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to one hundred thirty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to one hundred thirty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to thirty-two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(w) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special

revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the treatment of breast and cervical cancer pursuant to paragraph (d) of subdivision four of section three hundred sixty-six of the social services law, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four hundred fifty thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to two million one hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to two million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to two million one hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million one hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million one hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million one hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million one hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to five hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to two million one hundred thousand dollars each state fiscal

year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(x) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public general hospital rates increases for recruitment and retention of health care workers from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-seven million one hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) fifty million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixty-nine million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixty-nine million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two

thousand five;

(v) sixty-nine million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) sixty-five million three hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) sixty-one million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) forty-eight million seven hundred twenty-one thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(y) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public general hospitals for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) fifty-two million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) fifty-two million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) forty-nine million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) forty-nine million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) twelve million two hundred fifty thousand dollars for the period January first, two thousand nine through March thirty-first, two thousand nine.

Provided, however, amounts pursuant to this paragraph may be reduced in an amount to be approved by the director of the budget to reflect amounts received from the federal government under the state's 1115 waiver which are directed under its terms and conditions to the health workforce recruitment and retention program.

(z) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public residential health care facility rate increases for recruitment and retention of health care workers pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-one million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) forty-six million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) forty-six million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) forty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million nine hundred thousand dollars for the period

January first, two thousand seven through December thirty-first, two thousand seven;

(vii) twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) twelve million three hundred seventy-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) nine million three hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) two million three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(aa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public residential health care facilities for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixteen million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) sixteen million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) ten million eight hundred thousand dollars for the period January

first, two thousand seven through December thirty-first, two thousand seven;

(vii) six million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) one million three hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine.

(bb)(i) Funds shall be deposited by the commissioner, within amounts appropriated, and subject to the availability of federal financial participation, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which include a city with a population of over one million persons and computed and distributed in accordance with memorandums of understanding to be entered into between the state of New York and such local social service districts for the purpose of supporting the recruitment and retention of personal care service workers or any worker with direct patient care responsibility, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(A) forty-four million dollars, on an annualized basis, for the period April first, two thousand two through December thirty-first, two thousand two;

(B) seventy-four million dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(C) one hundred four million dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(D) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(E) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(F) one hundred thirty-six million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(G) one hundred thirty-six million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(H) one hundred thirty-six million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(I) one hundred thirty-six million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(J) thirty-four million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(K) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(L) up to one hundred thirty-six million dollars each state fiscal year for the period March thirty-first, two thousand fourteen through April first, two thousand seventeen;

(M) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(N) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(O) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(P) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(ii) Adjustments to Medicaid rates made pursuant to this paragraph shall not, in aggregate, exceed the following amounts for the following periods:

(A) for the period April first, two thousand two through December thirty-first, two thousand two, one hundred ten million dollars;

(B) for the period January first, two thousand three through December thirty-first, two thousand three, one hundred eighty-five million dollars;

(C) for the period January first, two thousand four through December thirty-first, two thousand four, two hundred sixty million dollars;

(D) for the period January first, two thousand five through December thirty-first, two thousand five, three hundred forty million dollars;

(E) for the period January first, two thousand six through December thirty-first, two thousand six, three hundred forty million dollars;

(F) for the period January first, two thousand seven through December thirty-first, two thousand seven, three hundred forty million dollars;

(G) for the period January first, two thousand eight through December thirty-first, two thousand eight, three hundred forty million dollars;

(H) for the period January first, two thousand nine through December thirty-first, two thousand nine, three hundred forty million dollars;

(I) for the period January first, two thousand ten through December thirty-first, two thousand ten, three hundred forty million dollars;

(J) for the period January first, two thousand eleven through March thirty-first, two thousand eleven, eighty-five million dollars;

(K) for each state fiscal year within the period April first, two thousand eleven through March thirty-first, two thousand fourteen, three hundred forty million dollars;

(L) for each state fiscal year within the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, three hundred forty million dollars;

(M) for each state fiscal year within the period April first, two thousand seventeen through March thirty-first, two thousand twenty, three hundred forty million dollars;

(N) for each state fiscal year within the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, three hundred forty million dollars;

(O) for each state fiscal year within the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, three hundred forty million dollars; and

(P) for each state fiscal year within the period April first, two

thousand twenty-six through March thirty-first, two thousand twenty-nine, three hundred forty million dollars.

(iii) Personal care service providers which have their rates adjusted pursuant to this paragraph shall use such funds for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility only and are prohibited from using such funds for any other purpose. Each such personal care services provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(cc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which shall not include a city with a population of over one million persons for the purpose of supporting the personal care services worker recruitment and retention program as established pursuant to section three hundred sixty-seven-q of the social services law, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

- (i) two million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;
- (ii) five million six hundred thousand dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eight million four hundred thousand dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(v) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eleven million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eleven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eleven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eleven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) two million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) up to eleven million two hundred thousand dollars each state

fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(dd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for physician services from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eighty-one million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eighty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eighty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eighty-five million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eighty-five million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eighty-five million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eighty-five million two hundred thousand dollars for the period

January first, two thousand ten through December thirty-first, two thousand ten;

(x) twenty-one million three hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) eighty-five million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ee) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the free-standing diagnostic and treatment center rate increases for recruitment and retention of health care workers pursuant to subdivision seventeen of section twenty-eight hundred seven of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million two hundred fifty thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) three million two hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) three million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) three million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) three million four hundred thirty-eight thousand dollars for the

period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) two million four hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ff) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for disabled persons as authorized pursuant to former subparagraphs twelve and thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) sixteen million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighteen million seven hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) thirty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) thirty million six hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) fifteen million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) fifteen million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) fifteen million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) fifteen million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) fifteen million dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(gg) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (c) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to one million three hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to three million two hundred thousand dollars on an annualized

basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to five million six hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eight million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight million six hundred thousand dollars on an annualized basis for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million six hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million six hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) up to six hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(hh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue fund - other, HCRA transfer fund, medical assistance account for purposes of providing financial assistance to residential health care facilities pursuant to subdivisions nineteen and twenty-one of section twenty-eight hundred eight of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) for the period April first, two thousand two through December thirty-first, two thousand two, ten million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, nine million four hundred fifty thousand dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, nine million three hundred fifty thousand dollars;

(iv) up to fifteen million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to fifteen million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to fifteen million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ii) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for disabled persons as authorized by sections 1619 (a) and (b) of the federal social security act pursuant to the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million four hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) eight million five hundred thousand dollars, for the period January first, two thousand three through December thirty-first, two

thousand three;

(iii) eight million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eight million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eight million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eight million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eight million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty;

(xiv) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xv) eight million five hundred thousand dollars each state fiscal

year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xvi) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(jj) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purposes of a grant program to improve access to infertility services, treatments and procedures, from the tobacco control and insurance initiatives pool established for the period January first, two thousand two through December thirty-first, two thousand two in the amount of nine million one hundred seventy-five thousand dollars, for the period April first, two thousand six through March thirty-first, two thousand seven in the amount of five million dollars, for the period April first, two thousand seven through March thirty-first, two thousand eight in the amount of five million dollars, for the period April first, two thousand eight through March thirty-first, two thousand nine in the amount of five million dollars, and for the period April first, two thousand nine through March thirty-first, two thousand ten in the amount of five million dollars, for the period April first, two thousand ten through March thirty-first, two thousand eleven in the amount of two million two hundred thousand dollars, and for the period April first, two thousand eleven through March thirty-first, two thousand twelve up to one million one hundred thousand dollars.

(kk) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medical Assistance Program expenditures from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) thirty-eight million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two hundred ninety-five million dollars for the period January first, two thousand three through December thirty-first, two

thousand three;

(iii) up to four hundred seventy-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to nine hundred million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight hundred sixty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to six hundred sixteen million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to five hundred seventy-eight million nine hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) within amounts appropriated on and after January first, two thousand nine.

(ll) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures related to the city of New York from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) one hundred twenty-four million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) thirty-one million one hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) one hundred twenty-four million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(mm) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding specified percentages of the state share of services and expenses related to the family health plus program in accordance with the following schedule:

(i) (A) for the period January first, two thousand three through December thirty-first, two thousand four, one hundred percent of the state share;

(B) for the period January first, two thousand five through December thirty-first, two thousand five, seventy-five percent of the state share; and

(C) for periods beginning on and after January first, two thousand six, fifty percent of the state share.

(ii) Funding for the family health plus program will include up to

five million dollars annually for the period January first, two thousand three through December thirty-first, two thousand six, up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to seven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to seven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to seven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to six million forty-nine thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to six million two hundred eighty-nine thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, and up to six million four hundred sixty-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, for administration and marketing costs associated with such program established pursuant to clauses (A) and (B) of subparagraph (v) of paragraph (a) of subdivision two of the former section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(A) one hundred ninety million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(B) three hundred seventy-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(C) five hundred thirty-eight million four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(D) three hundred eighteen million seven hundred seventy-five thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(E) four hundred eighty-two million eight hundred thousand dollars for

the period January first, two thousand seven through December thirty-first, two thousand seven;

(F) five hundred seventy million twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(G) six hundred ten million seven hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(H) six hundred twenty-seven million two hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(I) one hundred fifty-seven million eight hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(J) six hundred twenty-eight million four hundred thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(K) six hundred fifty million four hundred thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(L) six hundred fifty million four hundred thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen; and

(M) up to three hundred ten million five hundred ninety-five thousand dollars for the period April first, two thousand fourteen through March thirty-first, two thousand fifteen.

(nn) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes related to adult home initiatives for medicaid eligible residents of residential facilities licensed pursuant to section four hundred sixty-b of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(ii) up to six million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iii) up to eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(iv) up to eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(v) up to eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(vi) up to two million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(viii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(ix) up to six hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(oo) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (e) of subdivision twenty-five of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to five million dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vii) up to five million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(viii) up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(pp) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the provision of tax credits for long term care insurance pursuant to subdivision one of section one hundred ninety of the tax law, paragraph (a) of subdivision fourteen of section two hundred ten-B of such law, subsection (aa) of section six hundred six of such law and paragraph one of subdivision (m) of section fifteen hundred eleven of such law, in the following amounts:

(i) ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) ten million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) ten million dollars for the period January first, two thousand

six through December thirty-first, two thousand six; and

(iv) five million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

(qq) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the long-term care insurance education and outreach program established pursuant to section two hundred seventeen-a of the elder law for the following periods in the following amounts:

(i) up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iii) up to five million dollars for the period January first, two

thousand six through December thirty-first, two thousand six; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long-term care insurance resource centers with the necessary resources to carry out their operations;

(vii) up to four hundred eighty-eight thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand

ten; of such funds four hundred eighty-eight thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program.

(rr) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and shall be available, including income from invested funds, for the purpose of supporting expenses related to implementation of the provisions of title three of article twenty-nine-D of this chapter, for the following periods and in the following amounts:

(i) up to ten million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(ii) up to ten million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) up to ten million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) up to ten million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) up to ten million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(vi) up to two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ss) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and used for a health care stabilization program established by the commissioner for the purposes of stabilizing critical health care providers and health care programs whose ability to continue to provide appropriate services are threatened by financial or other challenges, in the amount of up to twenty-eight million dollars for the period July first, two thousand four through June thirtieth, two thousand five. Notwithstanding the provisions of section one hundred twelve of the state finance law or any other inconsistent provision of the state finance law or any other law, funds available for distribution pursuant to this paragraph may be allocated and distributed by the commissioner, or the state comptroller as applicable without a competitive bid or request for proposal process. Considerations relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (i)

the importance of the provider or program in meeting critical health care needs in the community in which it operates; (ii) the provider or program provision of care to under-served populations; (iii) the quality of the care or services the provider or program delivers; (iv) the ability of the provider or program to continue to deliver an appropriate level of care or services if additional funding is made available; (v) the ability of the provider or program to access, in a timely manner, alternative sources of funding, including other sources of government funding; (vi) the ability of other providers or programs in the community to meet the community health care needs; (vii) whether the provider or program has an appropriate plan to improve its financial condition; and (viii) whether additional funding would permit the provider or program to consolidate, relocate, or close programs or services where such actions would result in greater stability and efficiency in the delivery of needed health care services or programs.

(tt) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing grants for two long term care demonstration projects designed to test new models for the delivery of long term care services established pursuant to section twenty-eight hundred seven-x of this article, for the following periods and in the following amounts:

(i) up to five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(v) up to two hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(uu) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting disease management and telemedicine demonstration programs authorized pursuant to section twenty-one hundred eleven of this chapter for the following periods in the following amounts:

(i) five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(ii) five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iii) nine million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iv) nine million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and one million dollars shall be available for telemedicine demonstration programs;

(v) nine million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(vi) seven million eight hundred thirty-three thousand three hundred thirty-three dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and three hundred thirty-three thousand three hundred thirty-three dollars shall be available for telemedicine demonstration programs for the period January first, two thousand nine through March first, two thousand nine;

(vii) one million eight hundred seventy-five thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten shall be available for disease management demonstration

programs.

(ww) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for recruitment and retention of health care workers pursuant to paragraph (e) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) sixty million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(ii) sixty million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(xx) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for rural hospitals pursuant to subdivision thirty-two of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) three million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iii) three million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iv) three million five hundred thousand dollars for the period

January first, two thousand eight through December thirty-first, two thousand eight; and

(v) three million two hundred eight thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(yy) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated and notwithstanding section one hundred twelve of the state finance law and any other contrary provision of law, for the purpose of supporting grants not to exceed five million dollars to be made by the commissioner without a competitive bid or request for proposal process, in support of the delivery of critically needed health care services, to health care providers located in the counties of Erie and Niagara which executed a memorandum of closing and conducted a merger closing in escrow on November twenty-fourth, nineteen hundred ninety-seven and which entered into a settlement dated December thirtieth, two thousand four for a loss on disposal of assets under the provisions of title XVIII of the federal social security act applicable to mergers occurring prior to December first, nineteen hundred ninety-seven.

(zz) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated, for the purpose of supporting expenditures authorized pursuant to section twenty-eight hundred eighteen of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) one hundred eight million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iii) one hundred seventy-one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated in the two

thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iv) one hundred seventy-one million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(v) one hundred twenty-eight million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vi) one hundred thirty-one million three hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(vii) thirty-four million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(viii) four hundred thirty-three million three hundred sixty-six thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(ix) one hundred fifty million eight hundred six thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(x) seventy-eight million seventy-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen.

(aaa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for services and expenses related to school based health centers, in an amount up to three million five hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million five hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million five hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, up to three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to

two million eight hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, and up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine. The total amount of funds provided herein shall be distributed as grants based on the ratio of each provider's total enrollment for all sites to the total enrollment of all providers. This formula shall be applied to the total amount provided herein.

(bbb) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of awarding grants to operators of adult homes, enriched housing programs and residences through the enhancing abilities and life experience (EnAble) program to provide for the installation, operation and maintenance of air conditioning in resident rooms, consistent with this paragraph, in an amount up to two million dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million eight hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million eight hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million eight hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, and up to three million eight hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven. Residents shall not be charged utility cost for the use

of air conditioners supplied under the EnAbLe program. All such air conditioners must be operated in occupied resident rooms consistent with requirements applicable to common areas.

(ccc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the rates for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs and managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter for recruitment and retention of health care workers pursuant to subdivisions nine and ten of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-five million dollars for the period June first, two thousand six through December thirty-first, two thousand six;

(ii) fifty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) fifty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) fifty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) fifty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(vi) twelve million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(vii) up to fifty million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(viii) up to fifty million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(ix) up to fifty million dollars each state fiscal year for the period

April first, two thousand seventeen through March thirty-first, two thousand twenty;

(x) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three;

(xi) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six; and

(xii) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-nine.

(ddd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the medical assistance rates for providers for purposes of enhancing the provision, quality and/or efficiency of home care services pursuant to subdivision eleven of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following period in the amount of eight million dollars for the period April first, two thousand six through December thirty-first, two thousand six.

(eee) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, to the Center for Functional Genomics at the State University of New York at Albany, for the purposes of the Adirondack network for cancer education and research in rural communities grant program to improve access to health care and shall be made available from the tobacco control and insurance initiatives pool established for the following period in the amount of up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(fff) Funds shall be made available to the empire state stem cell trust fund established by section ninety-nine-p of the state finance law within amounts appropriated up to fifty million dollars annually and shall not exceed five hundred million dollars in total.

(ggg) Funds shall be deposited by the commissioner, within amounts

appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for hospital translation services as authorized pursuant to paragraph (k) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) sixteen million dollars for the period July first, two thousand eight through December thirty-first, two thousand eight; and

(ii) fourteen million seven hundred thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(hhh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for adjustments to inpatient rates of payment for general hospitals located in the counties of Nassau and Suffolk as authorized pursuant to paragraph (l) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period April first, two thousand eight through December thirty-first, two thousand eight; and

(ii) two million two hundred ninety-two thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(iii) Funds shall be reserved and set aside and accumulated from year to year and shall be made available, including income from investment funds, for the purpose of supporting the New York state medical indemnity fund as authorized pursuant to title four of article twenty-nine-D of this chapter, for the following periods and in the following amounts, provided, however, that the commissioner is

authorized to seek waiver authority from the federal centers for medicare and Medicaid for the purpose of securing Medicaid federal financial participation for such program, in which case the funding authorized pursuant to this paragraph shall be utilized as the non-federal share for such payments:

Thirty million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve.

2. (a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the tobacco control and insurance initiatives pool established pursuant to this section. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of such funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis five hundred thousand dollars, for collection and distribution of funds pursuant to this section shall be paid from such funds.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of pools established pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-l and twenty-eight hundred seven-m of this article for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine may be extended to provide for administration pursuant to this section and may be amended as may be necessary.

§ 2807-w. High need indigent care adjustment pool. Funds allocated pursuant to paragraph (p) of subdivision one of section twenty-eight hundred seven-v of this article, shall be deposited as authorized and used for the purpose of making medicaid disproportionate share payments

of up to eighty-two million dollars on an annualized basis pursuant to subdivision twenty-one of section twenty-eight hundred seven-c of this article, for the period January first, two thousand through March thirty-first, two thousand fourteen, in accordance with the following:

1. From the funds in the pool each year: (a) Each eligible rural hospital shall receive one hundred forty thousand dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand fourteen, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this paragraph exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit shall be provided as a nondisproportionate share payment in the form of a grant directly from this pool without allocation to the special revenue funds - other, indigent care fund - 068, or any successor fund or account, and provided further that payments for periods on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of section twenty-eight hundred seven-k of this article;

(b) Each such hospital shall also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section.

Rank	Percentage Coverage of Uncompensated Care Need
1-9	60.0%
10-17	52.5%
18-25	45.0%
26-33	37.5%
34-41	30.0%
42-49	22.5%
50-57	15.0%
58+	7.5%

For purposes of calculating the distribution amount to an eligible rural hospital which has merged with another hospital on or after

December thirty-first, nineteen hundred ninety-nine, and continues to be an eligible rural hospital in accordance with paragraph (c) of this subdivision, such merged facility's uncompensated care need pursuant to this paragraph shall be calculated from data provided in the eligible rural hospital's institutional cost report filed for the rate period two years prior to the distribution period, or if such report is not required for such rural hospital, the distribution amount shall be based upon the last institutional cost report required to be filed by such rural hospital.

(c) "Eligible rural hospital", as used in this section, shall mean a general hospital that as of December thirty-first, nineteen hundred ninety-nine or thereafter, was classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, or a general hospital, which during the same time period, had a service area which has an average population of less than one hundred seventy-five persons per square mile, or a general hospital which has a service area which has an average population of less than two hundred persons per square mile measured as population density by zip code. The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin or zip code as applicable for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the nineteen hundred ninety-seven rate year, as reported to the commissioner by October first, nineteen hundred ninety-eight. Population density shall be determined utilizing United States census bureau data for nineteen hundred ninety-seven. If an eligible rural hospital merges with another general hospital, on or after December thirty-first, nineteen hundred ninety-nine, and the merger results in separate facilities operating under a single facility operating certificate, such eligible rural hospital shall continue to be a separate eligible rural hospital for purposes of this subdivision and payments provided in accordance with this section shall be made to the merged entity; provided, however, that payments shall only be made to the merged entity if such separate eligible rural hospital continues to provide inpatient and/or outpatient hospital services at the same

location at which it operated prior to the merger. If an eligible rural hospital merges with another general hospital on or after December thirty-first, nineteen hundred ninety-nine, and the merger results in such rural hospital continuing to operate under a separate facility operating certificate, such rural hospital will continue to be an eligible rural hospital after the merger; provided, however, that payments shall only be made to such rural hospital if such eligible rural hospital continues to provide inpatient and/or outpatient hospital services at the same location at which it is operated prior to the merger.

(d) "Eligible rural hospital weight", as used in this section, shall mean the result of adding, for each eligible rural hospital:

(i) The eligible rural hospital's targeted need, as defined in section twenty-eight hundred seven-k of this article, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and

(ii) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.

2. From the funds in the pool each year, thirty-six million dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand fourteen, of the funds not distributed in accordance with subdivision one of this section, shall be distributed in accordance with the formula set forth in subdivision six of section twenty-eight hundred seven-k of this article, provided, however, that payments for periods on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of section twenty-eight hundred seven-k of this article.

3. From the funds in the pool each year, any funds not distributed in accordance with subdivision one or two of this section, shall be distributed in accordance with the formula set forth in paragraph (b) of subdivision four of section twenty-eight hundred seven-k of this article.

4. In order for a general hospital to be eligible to participate in

the distribution of funds pursuant to this section, such general hospital must be in compliance with the provisions of subdivisions nine, ten and twelve of section twenty-eight hundred seven-k of this article.

5. For each hospital receiving payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, the commissioner shall reduce the sum of any amounts paid pursuant to this section and pursuant to section twenty-eight hundred seven-k of this article, as computed based on projected facility specific disproportionate share hospital ceilings, by an amount equal to the lower of such sum or each such hospital's payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, provided, however, that any additional aggregate reductions enacted in a chapter of the laws of two thousand ten to the aggregate amounts payable pursuant to this section and pursuant to section twenty-eight hundred seven-k of this article shall be applied subsequent to the adjustments otherwise provided for in this subdivision.

§ 2807-x. Grants for long term care demonstration projects. 1. The commissioner shall establish three demonstration projects to develop, evaluate and implement programs to test new models for the organization and delivery of long term care services to encourage community based programs and smaller residential health care models in order to promote consumer choice, improve the efficiency and appropriateness of the use of state and federal resources and ensure the recruitment, retention and training of health care staff to adequately meet the needs of a community and residential long term care system. Notwithstanding the provisions of section one hundred twelve of the state finance law or any other inconsistent provision of the state finance law or any other law, funds available for distribution pursuant to this section may be allocated and distributed by the commissioner without a competitive bid or request for proposal process.

(a) The following factors shall be considered in approving each demonstration project respectively:

(i) Residential health care demonstration project. (A) the extent to

which there is a reduction in the need for skilled nursing beds for a facility that is eligible to replace its existing skilled nursing facility; (B) the potential to design and develop more appropriate smaller residential health care facilities as an alternative to replacing an existing skilled nursing facility; (C) the extent to which the quality, efficiency and continuity of care will be promoted and provided for by the development of integrated long-term care services in the community; (D) the extent to which the project will provide training to health care workers to appropriately staff new community based models of long term care; (E) demonstrate the involvement and support of workforce in the program redesign; (F) the development of a new long-term care reimbursement methodology that encourages care in the least restrictive setting and adequately reflects the resources needed to serve consumers in each level of long term care; (G) and the incorporation of a research component designed to evaluate the project.

(ii) Community based care demonstration project. (A) the extent to which there is a reduction in the need for skilled nursing facility beds on a countywide basis; (B) the development of a new system to inform recently admitted residents of skilled nursing facilities of the availability of community long-term care options; (C) the extent to which the discharge planning program from skilled nursing facilities will inform, assist and maximize freedom of choice to consumers who choose to move back to the community; (D) the extent to which the project will develop community based long term care services, including funding for the recruitment and retention of direct care health care workers necessary to increase community based services; (E) the extent to which the project will provide training to health care staff; and (F) the incorporation of a research component designed to evaluate the projects.

(iii) Managed long term care project. (A) the extent to which a current operator of skilled nursing facilities possesses the necessary authorizations through a related entity to assume risk and receive capitated payments, pursuant to titles 18 and 19 of the federal social security act, for the purpose of providing and arranging for the care of individuals eligible for admission to a skilled nursing facility, (B) the extent to which such services to individuals eligible for benefits pursuant to both titles 18 and 19 of the federal social security act

will be provided through the capitated rate, (C) the extent to which the quality, efficiency and continuity of care will be promoted and provided for by the development of integrated long-term care services in the community, (D) the extent to which the project sponsor will directly or indirectly in association with a joint labor management program, provide for training of health care workers to appropriately staff community based models of long-term care; and (E) the incorporation of a research component designed to evaluate the project, with specific reference to the determination of cost savings to the state, the quality of and satisfaction with services provided to consumers and their families and the satisfaction of direct care workers, with a report of the project's progress and findings submitted annually to the commissioner.

2. The commissioner is authorized to waive, modify or suspend the respective provisions of rules and regulations promulgated pursuant to this chapter if the commissioner determines that such waiver is necessary or appropriate for the successful implementation of a demonstration project and when the health, safety, and general welfare of persons receiving services under such demonstration project will not be impaired as a result of such waiver, modification or suspension, provided however, that for the managed long term care project pursuant to subparagraph (iii) of paragraph (a) of subdivision one of this section, the method for setting the capitated rate of payment under title 19 of the federal social security act shall be consistent with the method used for all managed long term care plans authorized under subdivision eight of section forty-four hundred three-f of the public health law.

3. The commissioner is authorized to seek federal waivers pursuant to titles XVIII and XIX of the federal social security act when such waivers are necessary to develop cost-effective long term care demonstration projects.

§ 2807-y. Pool administration. 1. For periods on and after January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other

contractors as the commissioner shall designate, to receive and distribute funds from the allowances and assessments established pursuant to:

(a) subdivision eighteen of section twenty-eight hundred seven-c of this article;

(b) section twenty-eight hundred seven-j of this article;

(c) section twenty-eight hundred seven-s of this article;

(d) section twenty-eight hundred seven-t of this article;

(e) section twenty-eight hundred seven-v of this article;

(f) section twenty-eight hundred seven-d of this article;

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

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

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

2. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the funds and beginning January first, two thousand sixteen shall provide records of all revenues and disbursements made from allocations and assessments listed in subdivision one of this section to the temporary president of the senate and speaker of the assembly on an annual basis.

3. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis four million five hundred fifty thousand dollars, increased annually by the lower of the consumer price index or five percent, for collection and distribution of allowances and assessments set forth in subdivision one of this section, shall be paid from the allowance and assessment funds.

4. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of the allowances and assessments set forth in subdivision one of this

section for the period January first, two thousand four through December thirty-first, two thousand four may be extended to provide for administration of the allowances and assessments pursuant to this section and amended as necessary.

§ 2807-z. Review of eligible federally qualified health center capital projects. 1. Notwithstanding any provision of this chapter or regulations or any other state law or regulation, for any eligible capital project as defined in subdivision six of this section, the department shall have thirty days of receipt of the certificate of need application for a limited or administrative review to deem such application complete. If the department determines the application is incomplete or that more information is required, the department shall notify the applicant in writing within thirty days of the date of the application's submission, and the applicant shall have twenty business days to provide additional information or otherwise correct the deficiency in the application.

2. For an eligible capital project requiring a limited or administrative review, within ninety days of the department deeming the application complete, the department shall make a decision to approve or disapprove the certificate of need application for such project. If the department determines to disapprove the project, the basis for such disapproval shall be provided in writing; however, disapproval shall not be based on the incompleteness of the application. If the department fails to take action to approve or disapprove the application within ninety days of the certificate of need application being deemed complete, the application will be deemed approved.

3. For an eligible capital project requiring full review by the council, the certificate of need application shall be placed on the next council agenda following the department deeming the application complete.

4. Where the commissioner or department requires the applicant to submit a contingency submission for an eligible capital project, the

commissioner or department shall have thirty days to review and approve or disapprove the contingency submission. If the commissioner or department determines that the contingency submission is incomplete, it shall so notify the applicant in writing and provide the applicant with ten business days to correct the deficiency or provide additional information. If the commissioner or department determines to disapprove the contingency submission, the basis for such disapproval shall be provided in writing; however, disapproval shall not be based on the incompleteness of the application. Within fifteen days of complete contingency satisfaction, the commissioner or department shall transmit the final approval letter to the applicant.

5. The department shall develop expedited pre-opening survey processes for eligible capital projects approved under this section, but under no circumstances shall pre-opening survey reviews be scheduled later than thirty days after final approval, construction completion and notification of such completion of the department.

6. Definitions. For the purposes of this section the following terms shall be defined as follows:

(a) "Eligible capital project" shall mean:

(i) A project that does not involve the establishment of a new operator pursuant to section twenty-eight hundred one-a of this article, with a total budget of three million dollars or more funded, in whole or in part, with federal monies pursuant to section 330 of the Public Health Service (PHS), 42 USC 254b, as amended; or

(ii) A project that does not involve the establishment of a new operator pursuant to section twenty-eight hundred one-a of this article, with a total budget of three million dollars or more funded, in whole or in part, with federal monies pursuant to the federal Capital Development-Building Capacity (CD-BC) Grant Program and Immediate Facility Improvements (CD-IFI) Grant Program, as authorized by the Patient Protection and Affordable Care Act (Affordable Care Act)((P.L. 111-148), Section 10503(c)).

(b) "Budget" shall mean the budget for the capital project.

7. Capital projects, with a total budget of less than three million

dollars that do not involve the establishment of a new operator pursuant to section twenty-eight hundred one-a of this article, funded in whole or in part through section 330 of the Public Health Service (PHS), 42 USC 254b, as amended, or through the federal Capital Development-Building Capacity (CD-BC) Grant Program and Immediate Facility Improvements (CD-IFI) Grant Program, as authorized by the Patient Protection and Affordable Care Act (Affordable Care Act)((P.L. 111-148), Section 10503(c)), shall not be subject to the requirements set forth in this section or any other law or regulation regarding certificate of need process or requirements.

8. For capital projects exempt from certificate of need requirements pursuant to subdivision seven of this section, the department shall (a) establish mechanisms to account for the capital costs of such projects in the applicant's rate of payment by governmental agencies established pursuant to section twenty-eight hundred seven of this article; (b) establish licensure requirements for such facility, which shall include payment of the fees specified at subdivision seven of section twenty-eight hundred two of this article; and (c) deem such facilities eligible for uncompensated care reimbursement made available pursuant to section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven, as amended by section seventy-five of chapter one of the laws of nineteen hundred ninety-nine.

9. The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this section. To the extent that the commissioner has not promulgated such regulations, projects that would otherwise be exempt from certificate of need requirements may be processed, at the option of the applicant, in accordance with statutes and regulations governing the certificate of need process.

§ 2808. Residential health care facilities; rates of payment.

1-a. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent

provision of law, the commissioner shall make grants to public residential health care facilities without a competitive bid or request for proposal process for the purposes of addressing the overall increases in input costs borne by such facilities. Such modifications shall also be primarily intended to promote the provision of quality health care, quality operation, updated technology and improved staff development and support by such facilities. Such grants shall be in the following aggregate amounts for the following periods: five million for the period April first, two thousand six through March thirty-first, two thousand seven; fifteen million for the period April first, two thousand seven through March thirty-first, two thousand eight; and ten million for the period April first, two thousand eight through March thirty-first, two thousand nine.

The amount allocated to each eligible public residential health care facility for each period shall be calculated as the result of (i) the total payment for each period multiplied by (ii) the ratio of patient days for patients eligible for medical assistance pursuant to title eleven of article five of the social services law provided by the public residential health care facility, divided by the total of such patient days summed for all eligible public residential health care facilities. Grants under this subdivision shall be made on a quarterly basis.

* 2. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, relating the rate of payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as the age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by

circumstances reasonably under the control of the facility.

(d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

* NB Expired December 31, 1978

2-a. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-nine, relating the rate of payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as the age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility.

* (d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity, and further provided that,

subject to federal financial participation, and subject to the approval of the commissioner, effective April first, two thousand fifteen, the commissioner may modify such payments for real property costs for purposes of effectuating a shared savings program, whereby facilities share a minimum of fifty percent of savings, for facilities that elect to refinance their mortgage loans. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

* NB Effective until March 31, 2030

* (d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

* NB Effective March 31, 2030

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

2-b. Notwithstanding any inconsistent provision of this section, or any other contrary provision of law and subject to the availability of federal financial participation, the operating cost component of rates of payment by governmental agencies for inpatient services provided on and after January first, two thousand seven by residential health care facilities shall be in accordance with the following:

(a) (i) Subject to the provisions of subparagraphs (ii) through (vi) of this paragraph, for the two thousand seven rate period the operating cost component of rates of payment shall reflect the operating cost component of rates effective for October first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article; and for the

January first, two thousand eight through March thirty-first, two thousand nine rate period the operating cost component of rates of payment shall reflect the operating cost component of rates effective for December thirty-first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article.

(ii) Rates for the periods two thousand seven and two thousand eight shall be further adjusted by a per diem add-on amount, as determined by the commissioner, reflecting the proportional amount of each facility's projected Medicaid benefit to the total projected Medicaid benefit for all facilities of the imputed use of the rate-setting methodology set forth in paragraph (b) of this subdivision, provided, however, that for those facilities that do not receive a per diem add-on adjustment pursuant to this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, provided, further, however, that the aggregate total of the rate adjustments made pursuant to this subparagraph shall not exceed one hundred thirty-seven million five hundred thousand dollars for the two thousand seven rate period and one hundred sixty-seven million five hundred thousand dollars for the two thousand eight rate period and provided further, however, that such rate adjustments as made pursuant to this subparagraph prior to two thousand twelve shall not be subject to subsequent adjustment or reconciliation.

(iii) Revisions to two thousand six rates occurring on and after January first, two thousand seven, shall be annually incorporated, retroactively and prospectively, into two thousand seven and two thousand eight rates on or about November thirtieth, two thousand seven and November thirtieth, two thousand eight, respectively.

(iv) The capital cost component of rates pursuant to this paragraph shall fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year.

(v) Rates for the two thousand seven and two thousand eight rate periods, as computed pursuant to this paragraph, shall not be subject to case mix adjustment, provided, however, that a facility may, in

accordance with its existing full house schedule of submission of patient review instruments, submit data in support of a request for a rate adjustment to reflect an increased facility case mix equal to or greater than .05, provided further, however, that such a facility will be required to continue to make such full house submissions in accordance with its existing submission schedule for rate periods up through December thirty-first, two thousand eight.

(vi) For the period January first, two thousand seven through December thirty-first, two thousand eight, notwithstanding any contrary provision of law or regulation, voluntary facilities shall not be required to deposit reimbursement received for depreciation expenses into a segregated depreciation fund account.

(b) (i) (A) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utilizing allowable operating costs as reported in such

subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

(B) For the purposes of this subparagraph qualifying facilities are those facilities for which the commissioner determines that their reported two thousand two base year operating cost component, as defined in accordance with the regulations of the department as set forth in 10 NYCRR 86-2.10(a)(7); is less than the operating component such facilities received in the two thousand eight rate period, as adjusted by applicable trend factors.

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

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

(iii) Specified adjustments to the operating component of rates in effect for periods prior to January first, two thousand nine, with regard to extended care for persons with traumatic brain injury and for the cost of providing hepatitis B vaccinations shall continue on and after January first, two thousand nine.

(iv) The capital cost component of rates on and after January first, two thousand nine shall: (A) fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in

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

(v) The direct component of the operating component of rates of payment shall include allowable direct therapy costs and associated overhead costs and shall exclude administrative overhead costs related to pharmacy services and the costs of non-prescription drugs and supplies, which shall be reflected in facility rates as non-comparable costs.

(vi) For purposes of computing peer group cost ceilings for the direct and indirect component of the operating component of rates, facilities shall be organized into peer groups consisting of: (A) free-standing facilities with certified bed capacities of less than three hundred beds; (B) free-standing facilities with certified bed capacities of three hundred beds or more; and (C) hospital based facilities.

(vii) In determining the operating cost component of rates, for each peer group, a corridor shall be developed around the statewide mean direct and indirect price per day, provided, however, that the corridor around each mean direct and indirect price per day shall have a base no

less than eighty-five percent and no greater than ninety percent of each mean direct and indirect price per day and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each mean direct and indirect price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.

(viii) The operating component of rates shall be adjusted to reflect a per diem add-on amount of eight dollars, trended forward to reflect applicable inflation factors from two thousand six to two thousand nine and prospectively thereafter, for each patient who: (A) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (B) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B or C, or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

(ix) The operating component of rates shall be adjusted to reflect a per diem add-on amount of seventeen dollars, trended forward to reflect applicable inflation factors from two thousand six to two thousand nine and prospectively thereafter, for each patient whose body mass index is greater than thirty-five.

(x) For periods on and after January first, two thousand nine, notwithstanding any contrary provision of law or regulation, voluntary facilities shall not be required to deposit reimbursement received for depreciation expenses into a segregated depreciation fund account.

(xi) Public facilities, and non-public facilities with fewer than eighty certified beds, which have a facility specific direct adjusted payment price per day equal to the ceiling direct price per day shall have such direct adjusted payment price per day further adjusted through the addition of fifty percent of the difference between the facility's specific direct cost per day and the ceiling direct price per day. Public facilities, and non-public facilities with fewer than eighty certified beds, which have a facility specific indirect adjusted payment price per day equal to the ceiling indirect price per day shall have such indirect adjusted payment price per day further adjusted through the addition of fifty percent of the difference between the facility's specific indirect cost per day and the ceiling indirect price per day.

Such adjustments to direct and indirect adjusted payment prices per day shall be increased to the rate year by application of the applicable inflation factor and adjusted by the regional direct and indirect input price adjustment factors calculated pursuant to subdivision seventeen of this section.

(xii) Public facilities shall receive rates that are consistent with the provisions of this paragraph, provided, however, that in no event shall such rates, in aggregate, exceed the amount permitted under federal upper payment limits applicable to public facilities. In the event such public facilities are, pursuant to this subparagraph, subject to limitations on such rates, the commissioner shall make grants from state funds to such facilities equal to one-half of the additional amount that such facilities would have received if such limitations had not been applied.

(xiii) The appointment of a receiver or the establishment of a new operator or replacement or renovation of an existing facility on or after January first, two thousand seven shall not result in a revision to the operating component of the facility's rates for any rate period through December thirty-first, two thousand eleven, provided, however, that the provisions of this subparagraph shall not apply to a facility which has a certificate of need application filed with the department as of December thirty-first, two thousand six, which is subsequently approved and which otherwise meets existing department criteria for the establishment of a new base year for rate-setting purposes.

(xiv) The commissioner may promulgate regulations, including emergency regulations, to implement the provisions of this paragraph.

(c) In order to ensure that the quality of resident care is maintained and improved for rate periods on and after January first, two thousand seven, no less than sixty-five percent of the additional Medicaid reimbursement received by a residential health care facility that is attributable to the per-diem add-on amount received pursuant to subparagraph (ii) of paragraph (a) of this subdivision or, for rate periods on and after January first, two thousand nine, that is related to utilization of two thousand two reported base year costs, as compared to the reimbursement each such facility would have received had such facility's Medicaid reimbursement rates continued to reflect base year costs used with regard to such facility's two thousand six rates, shall

be allocated for the purpose of recruitment and retention of non-supervisory workers or any worker with direct resident care responsibility or for purposes authorized under the nursing home quality improvement demonstration program as established by section twenty-eight hundred eight-d of this article, provided, however, in no circumstance shall facilities be required to spend more than seventy-five percent of such funds for these purposes, and provided further, the commissioner is authorized to audit each such facility for the purpose of ensuring compliance with the provisions of this paragraph and shall recoup any amount determined to have been in contravention of the requirements of this paragraph, provided, however, that, upon application of a facility, the commissioner may, after determining that other funds are not available, waive the application of this paragraph insofar as it is determined by the commissioner that additional funds must be expended by such facility to correct deficiencies that constitute a threat to resident safety.

(d) Cost reports submitted by residential health care facilities for the two thousand two calendar year or any part thereof shall, notwithstanding any contrary provision of law, be subject to audit through December thirty-first, two thousand eighteen and facilities shall retain for the purpose of such audits all fiscal and statistical records relevant to such cost reports, provided, however, that any such audit commenced on or before December thirty-first, two thousand eighteen, may be completed and used for the purpose of adjusting any Medicaid rates which utilize such costs.

(e) For rate periods subsequent to two thousand nine which utilize reported costs from a base year subsequent to two thousand two, the following categories of facilities, as established pursuant to applicable regulations, shall receive rates that are no less than equivalent, as determined by the commissioner, to the rates that were in effect for such facilities on December thirty-first, two thousand six, trended forward for inflation to the applicable rate period: (A) AIDS facilities or discrete AIDS units within facilities, (B) discrete units for residents receiving care in a long term inpatient rehabilitation program for traumatic brain injured persons, (C) discrete units for long term ventilator dependent residents, (D) discrete units providing specialized programs for residents requiring behavioral interventions,

and (E) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(f) The operating component of Medicaid rates of payment shall, by no later than the two thousand twelve rate period, be based on allowable costs, as reported on annual facility cost reports, from a base year period no earlier than three years prior to the initial rate year, and then trended forward by applicable inflation factors. Thereafter, the base year utilized for rate-setting purposes shall be updated to be current no less frequently than every six years provided, however, that for the purposes of this paragraph, current shall mean that the operating components of the initial rate year utilizing such updated base year shall reflect allowable costs as reported in annual facility cost reports for periods no earlier than three years prior to such initial rate year and then trended forward to the rate year in accordance with applicable inflation factors.

(g) Notwithstanding any contrary provision of this subdivision or any other contrary provision of law, rule or regulation, rates of payment for inpatient services provided on and after April first, two thousand nine by residential health care facilities shall, except for the establishment of any statewide or any peer group base, mean or ceiling prices per day, be calculated utilizing only the number of patients properly assessed and reported in each patient classification group and eligible for medical assistance pursuant to title eleven of article five of the social services law.

(h) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period April first, two thousand eleven through June thirtieth, two thousand eleven, the non-capital components of rates shall be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of twenty-seven million one hundred thousand dollars, and provided further, however, that such reductions shall be disregarded in computations made pursuant to section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

2-c. (a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of

federal financial participation, the non-capital component of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on or after October first, two thousand eleven, but no later than January first, two thousand twelve, shall reflect a direct statewide price component, and indirect statewide price component, and a facility specific non-comparable component, utilizing allowable operating costs for a base year as determined by the commissioner by regulation. Such rate components shall be periodically updated to reflect changes in operating costs.

(b) The direct and indirect statewide price components shall be adjusted by a wage equalization factor and such other factors as determined to be appropriate to recognize legitimate cost differentials and the direct statewide price component shall be subject to a case mix adjustment utilizing the patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law. Such wage equalization factor shall be periodically updated to reflect current labor market conditions.

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

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

(e) With the exception of those enrollees covered under a payment rate methodology agreement negotiated with a residential health care facility, payments for inpatient residential health care facility services provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law made by organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law, shall be the rates of payment that would be paid for such

patients under the medical assistance program as determined pursuant to this section and subdivision ten of section twenty-eight hundred seven-d of this article and as in effect at the time such services were provided. The provisions of this paragraph shall not apply to payments for patients whose placement in a residential health care facility is for the purpose of receiving time-limited rehabilitation, to be followed by discharge from the facility, during the period such time-limited services are provided.

(f) The commissioner shall establish a prospective per diem adjustment for all nursing homes, other than nursing homes providing services primarily to children under the age of twenty-one, beginning April first, two thousand seventeen and each year thereafter sufficient to achieve eighteen million dollars in savings in each state fiscal year.

* (g) Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to this article located in a county with a population of more than seventy-two thousand and less than seventy-five thousand persons based on the two thousand ten federal census, and operating between one hundred ten and one hundred thirty beds, being reimbursed by the department on a fee-for-services basis, shall be reimbursed at a rate of no less than one hundred seventeen percent of the fee-for-service rate of reimbursement calculated pursuant to this section for that facility for inpatient services provided on or after March first, two thousand eighteen.

* NB There are 2 par (g)'s

* (g) The commissioner shall reduce Medicaid revenue to a residential health care facility in a payment year by two percent if in each of the two most recent payment years for which New York state nursing home quality initiative data is available, the facility was ranked in the lowest two quintiles of facilities based on its nursing home quality initiative performance, and was ranked in the lowest quintile in the most recent payment year. The commissioner shall waive the application of this paragraph to a facility if the commissioner determines that the facility is in financial distress.

* NB There are 2 par (g)'s

2-d. Residential health care facility supplemental payments.

Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation, for the period May first, two thousand eleven through May thirty-first, two thousand eleven, the commissioner shall adjust inpatient medicaid rates of payment established pursuant to this article for eligible residential health care facilities in accordance with the following:

(a) Rate adjustments made pursuant to this subdivision shall be in the form of rate add-ons and shall not exceed an aggregate amount of two hundred twenty-one million three hundred thousand dollars.

(b) Eligible facilities are those facilities which the commissioner determines have experienced a net reduction in their inpatient Medicaid reimbursement for the period April first, two thousand nine through March thirty-first, two thousand eleven as a result of the following:

(i) inpatient rate adjustments made pursuant to paragraph (b) of subdivision two-b of this section;

(ii) use of the case mix methodology described in paragraph (g) of subdivision two-b of this section;

(iii) inpatient rate adjustments made pursuant to section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

(c) The following eligible facilities shall receive rate adjustments pursuant to this subdivision equal to one hundred percent of their net reimbursement reduction as computed by the commissioner in accordance with paragraph (b) of this subdivision:

(i) facilities that have been determined by the commissioner as being eligible for distributions of amounts available for the two thousand nine period as provided in subdivision twenty-one of this section;

(ii) non-public facilities whose total operating losses equal or exceed five percent of total operating revenue and whose medicaid utilization equals or exceeds seventy percent, based on either their two thousand nine cost report or based on the otherwise most recently available cost report, as determined by the commissioner;

(iii) facilities or distinct units of facilities providing inpatient services primarily to children under the age of twenty-one.

(d) Eligible facilities, other than eligible facilities described in paragraph (c) of this subdivision, shall receive rate adjustments pursuant to this subdivision equal to fifty percent of their net reimbursement reduction as computed by the commissioner in accordance

with paragraph (b) of this subdivision.

(e) Eligible facilities as described in paragraph (d) of this subdivision which, as determined by the commissioner, after application of the rate adjustments authorized by paragraph (d) of this subdivision, remain subject to a net reduction in their inpatient Medicaid revenue that is in excess of two percent, as measured with regard to the non-capital components of facility inpatient rates in effect on March thirty-first, two thousand nine as computed prior to the application of trend factor adjustments attributable to the two thousand eight and two thousand nine calendar years, shall have their rates further adjusted such that such net reduction does not exceed such two percent.

(f) Eligible facilities as described in paragraph (d) of this subdivision which, as determined by the commissioner, have experienced a net reduction in their inpatient rates of more than six million dollars as a result of the application of the factor described in subparagraph (iii) of paragraph (b) of this subdivision shall after application of the provisions of paragraph (e) of this subdivision, have their rates further adjusted such that any such net reduction remaining after the application of the other provisions of this subdivision is reduced to zero.

(g) In computing net reductions of medicaid reimbursement pursuant to paragraph (b) of this subdivision the commissioner shall:

(i) disregard the impact of case mix adjustments as otherwise scheduled for July first, two thousand ten; and,

(ii) disregard the impact of any rate adjustments issued on or after January first, two thousand eleven, including adjustments to rate periods prior to January first, two thousand eleven.

(h) Payments made pursuant to this subdivision shall not be subject to subsequent adjustment or reconciliation and, further, the computation and application of limitations on medicaid rates of payment as described in section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended, and as applicable to the rate periods described in paragraph (a) of this subdivision, shall disregard payments made pursuant to this subdivision.

(i) Additional rate adjustments shall be made pursuant to this subdivision to eligible facilities in the form of rate add-ons for the period May first, two thousand eleven through May thirty-first, two

thousand eleven which shall in aggregate be equal to twenty-five percent of the aggregate amount described in paragraph (a) of this subdivision and which shall be distributed to each eligible facility in the same proportion as the total distributions otherwise received by each facility pursuant to this subdivision.

(j) The commissioner may, with the approval of the director of the budget, and subject to the identification of sufficient nursing home related medicaid savings to offset the expenditures authorized by this paragraph, make additional rate adjustments pursuant to this subdivision to eligible facilities in the form of rate add-ons for the period December first, two thousand eleven through December thirty-first, two thousand eleven which shall in aggregate be equal to twelve and five-tenths percent of the aggregate amount described in paragraph (a) of this subdivision and which shall be distributed to each eligible facility in the same proportion as the total distributions otherwise received by each facility pursuant to this subdivision.

3. The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, which shall relate the rate of payment to the efficient operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with the requirements of subdivision three of section twenty-eight hundred seven of this chapter and with federal laws and regulations.

4. The commissioner, in determining and certifying to the director of the budget the rates of payment to residential health care facilities, shall exclude the following costs: (a) contributions or other payments to political parties, candidates or organizations; (b) direct or indirect costs incurred for advertising or promotion except as allowed by the commissioner; (c) costs incurred for the promotion or opposition, directly or indirectly, of the passage of bills or resolutions pending before or passed by a legislative body of any jurisdiction; (d) costs which principally afford diversion, entertainment or amusement to their owners, operators or employees not properly related to patient care or treatment; (e) any penalty imposed by governmental agencies or courts,

and the costs of policies obtained solely to insure against the imposition of such a penalty; and (f) costs incurred by the residential health care facility to obtain the security required under the provisions of section twenty-eight hundred nine of this chapter.

5. (a) Any operator withdrawing equity or assets from a hospital operated for profit so as to create or increase a negative net worth or when the hospital is in a negative net worth position, calculated without regard to any surplus created by revaluation of assets, must obtain the prior approval of the commissioner in accordance with regulations promulgated by the commissioner with the approval of the state hospital review and planning council. The commissioner shall make a determination to approve or disapprove a request for withdrawal of equity or assets under this subdivision within sixty days of the date of the receipt of such a request. Requests shall be made in a form acceptable to the department by certified or registered mail. In addition to any other remedy or penalty available under this chapter, and after opportunity for a hearing, the commissioner may require replacement of the withdrawn equity or assets and may impose a penalty for violation of the provisions of this subdivision, relating to withdrawing equity or assets, or the regulations promulgated thereunder, in an amount not to exceed ten percent of any amount withdrawn without prior approval. No facility shall enter into a real property mortgage or lease transaction without thirty days prior notice in writing to the commissioner.

(b) On and after April first, two thousand ten, no non-public residential health care facility may withdraw equity or transfer assets which in the aggregate exceed:

(i) three percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner; or

(ii) in the case of a residential health care facility which (1) over the two immediately preceding successive quarters for which relevant data is available to the department, has been compliant with the minimum staffing level requirements prescribed by section twenty-eight hundred ninety-five-b of this chapter; (2) is not in the special focus facility

program operated by the centers for medicare and Medicaid services or subject to a denial of payment for new admissions imposed by the centers for medicare and Medicaid services; and (3) has not been the subject of an enforcement action brought by the department or the centers for medicare and Medicaid services in the previous eighteen months that resulted in a finding of deficiency, five percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner. Notification shall be made in a form acceptable to the department by certified or registered mail.

(c) Notwithstanding any inconsistent provision of this subdivision, on and after April first, two thousand ten, no non-public residential health care facility, whether operated as a for-profit facility or as a not-for-profit facility, may withdraw equity or transfer assets which in the aggregate exceed:

(i) three percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without the prior written approval of the commissioner; or

(ii) in the case of a residential health care facility which (1) over the two immediately preceding successive quarters for which relevant data is available to the department, has been compliant with the minimum staffing level requirements prescribed by section twenty-eight hundred ninety-five-b of this chapter; (2) is not in the special focus facility program operated by the centers for medicare and Medicaid services or subject to a denial of payment for new admissions imposed by the centers for medicare and Medicaid services; and (3) has not been the subject of an enforcement action brought by the department or the centers for medicare and Medicaid services in the previous eighteen months that resulted in a finding of deficiency, five percent of such facility's total reported annual revenue for patient care services, based on the facility's most recently available reported data, without prior written notification to the commissioner. The commissioner shall make a determination to approve or disapprove a request for withdrawal of equity or assets under this subdivision within sixty days of the date of the receipt of a written request from the facility. Requests shall be made in a form acceptable to the department by certified or registered

mail. In reviewing such requests the commissioner shall consider the facility's overall financial condition, any indications of financial distress, whether the facility is delinquent in any payment owed to the department, whether the facility has been cited for immediate jeopardy or substandard quality of care, and such other factors as the commissioner deems appropriate. In addition to any other remedy or penalty available under this chapter, and after opportunity for a hearing, the commissioner may require replacement of the withdrawn equity or assets and may impose a penalty for violation of the provisions of this subdivision in an amount not to exceed ten percent of any amount withdrawn without prior approval.

* 6. Prior to the approval by the state hospital review and planning council of any regulations promulgated pursuant to this section, the commissioner shall convene a public hearing, upon at least seven days notice, to consider the proposed regulations. The commissioner shall include a summary of the comments made at such hearing in a report to the state hospital review and planning council at the meeting at which it considers the regulations for approval.

* NB Expired December 31, 1985

* 7. The commissioner may assess an annual fee on each residential health care facility to be used to reimburse any first instance appropriation for the purpose of making payments to receivers pursuant to subdivision three of section twenty-eight hundred ten of this article. Such fee shall not exceed thirty dollars per bed certified pursuant to this article, and shall be a reimbursable expense for the purposes of determining rates of payment made by government agencies. The reimbursement rate for a facility must reflect the cost of the annual fee prior to requiring that the facility pay the fee. The commissioner shall seek to obtain federal approval to include such fee as a reimbursable expense for purposes of computing reimbursement rates pursuant to title XVIII of the federal social security act.

* NB (Effective pending Federal Law - Expired December 31, 1983)

8. Every lease or lease renewal executed on or after September first, nineteen hundred eighty-six between a landlord and the operator of a residential health care facility shall contain a provision terminating any interest the operator of such facility may have in any lease of

premises used for the operation of such facility after the public health council has approved the establishment of a new operator. Nothing herein shall be construed to affect any interest such operator may have in any movable equipment located on the premises of the facility. In the event any lease or lease renewal executed on or after September first, nineteen hundred eighty-six fails to contain the termination provision required by this subdivision, the lease or lease renewal shall be deemed to be terminated upon the public health council approval of a new operator. The commissioner, the landlord, or the new operator shall be entitled to maintain a summary proceeding to recover possession of the real property in any court of competent jurisdiction upon such termination.

9. Trend factors. (a) The commissioner, in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision, shall establish trend factors to project for the effect of inflation. The factors shall be applied to the appropriate portion of reimbursable costs of residential health care facilities. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for nonsupervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner pursuant to paragraph (b) of subdivision ten of section twenty-eight hundred seven-c of this chapter. On or about September first of each year following the effective date of this subdivision, the consultants shall provide to the commissioner and the council the methodology to be used to determine the trend factors for subsequent rate periods only, beginning with the nine month period commencing April first, nineteen hundred ninety-one and for subsequent twelve month periods commencing January first, nineteen hundred ninety-two and thereafter. The commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective

interim annual adjustment to the trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factor was established.

11. Residential health care facility reimbursement rate promulgation. With regard to a residential health care facility, the provisions of subdivision seven of section twenty-eight hundred seven of this article relating to advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are based on rate appeals filed by such facility, audits, changes in patient conditions or acuity levels, the correction of errors or omissions of data or errors in the computations of such rates, the submission of cost report data from facilities without an established cost basis, the judicial annulment or invalidation of existing rates or changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of existing rates or as otherwise authorized by law. Notwithstanding any inconsistent provision of law or regulation, as of April first, two thousand nine, with regard to administrative rate appeals, the department will only review such appeals for (a) the correction of computational errors or omissions of data by the department in determining the operating rate based upon the information provided to the department prior to the computation of the rate, (b) capital cost reimbursement, or (c) such reasons as the commissioner determines are appropriate. The department will not consider any revisions made to a facility's annual cost report for operating rate adjustment purpose later than the due date established by the commissioner.

12. (a) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall increase rates of payment established pursuant to this article for non-state operated public residential health care facilities in an aggregate amount not to exceed one hundred million dollars in additional reimbursement for payments for services provided during the period July first, nineteen hundred ninety-five

through March thirty-first, nineteen hundred ninety-six. The commissioner may adopt rules and regulations necessary to implement this paragraph.

(b) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of two hundred fifty-seven million dollars in additional payments in the period August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven.

(c) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of \$631.1 million in additional payments in the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, and a like amount in the period April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine.

(d) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate

amount of \$914.5 million in additional payments in the period April first, nineteen hundred ninety-nine through March thirty-first, two thousand.

(e) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau and the county of Westchester, but excluding public residential health care facilities operated by a town or city within a county, in an aggregate amount of up to \$991.5 million in additional payments each state fiscal year for the period beginning April first, two thousand through March thirty-first, two thousand five.

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

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

(f) The amount allocated to each eligible public residential health care facility for each period shall be calculated as the result of (A) the total payment for each period multiplied by (B) the ratio of patient days for patients eligible for medical assistance pursuant to title eleven of article five of the social services law provided by the public residential health care facility, divided by the total of such patient days summed for all eligible public residential health care facilities. For the period August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, nineteen hundred ninety-four patient days shall be utilized; for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, nineteen hundred ninety-five patient days shall be utilized; for the period April first, nineteen hundred ninety-eight

through March thirty-first, nineteen hundred ninety-nine, nineteen hundred ninety-six patient days shall be utilized; for the period April first, nineteen hundred ninety-nine through March thirty-first, two thousand, nineteen hundred ninety-seven patient days shall be utilized; for the period April first, two thousand through March thirty-first, two thousand one, nineteen hundred ninety-eight patient days shall be utilized; for the period April first, two thousand one through March thirty-first, two thousand two, nineteen hundred ninety-nine patient days shall be utilized; for the period April first, two thousand two through March thirty-first, two thousand three, two thousand patient days shall be utilized; for the period April first, two thousand three through March thirty-first, two thousand four, two thousand one patient days shall be utilized; for the period April first, two thousand four through March thirty-first, two thousand five, two thousand two patient days shall be utilized.

(f-1) Funds allocated by the provisions of paragraph (e-1) of this subdivision for distribution pursuant to this paragraph, shall be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made pursuant to this subdivision for state fiscal year periods beginning April first, two thousand six.

(g) Payments may be made based on adjustments to rates of payment for services provided during the applicable period or as lump sum payments to an eligible residential health care facility.

13. Notwithstanding any inconsistent provision of law or regulation to the contrary, residential health care facility rates of payment determined pursuant to this article for governmental agencies for services provided on or after July first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be reduced by the commissioner, to reflect the elimination of operational requirements previously mandated by law or, consistent with the standards specified in subparagraph (v) of paragraph (a) of subdivision two of section twenty-eight hundred three of this article, regulation or the commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential

health care facility as the result of (A) fifty-six million dollars on an annualized basis for nineteen hundred ninety-five, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (B) the ratio of patient days for patients eligible for payments made by governmental agencies provided in a base year two years prior to the rate year by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

14. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on or after April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-nine and for services provided on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six, the reimbursable base year administrative services and fiscal services costs, as defined in the New York state residential health care facility accounting and reporting manual, of a residential health care facility, excluding a provider of services reimbursed on an initial budget basis, shall, except as otherwise provided in this subdivision, not exceed the statewide average of total reimbursable base year administrative and fiscal services costs of residential health care facilities. For the purposes of this subdivision, reimbursable base year administrative and fiscal services costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group cost ceilings or guidelines.

(b) A separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July first, two thousand through March thirty-first, two thousand one, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through December thirty-first, two thousand six, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of such separate statewide average result in a change in the statewide average determined under paragraph (a) of this subdivision.

(c) The limitation on reimbursement for provider administrative and fiscal expenses provided by this subdivision shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each residential health care facility.

15. Notwithstanding any inconsistent provision of law or regulation to the contrary, for services provided by residential health care facilities for the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six, the commissioner shall not be required to revise a certified rate of payment established pursuant to this article based on consideration of rate appeals filed by a residential health care facility. In cases where the commissioner determines that a significant financial hardship exists, he or she may, subject to the approval of the director of the budget, consider an exemption to this subdivision. Beginning April first, nineteen hundred ninety-six and thereafter, the commissioner shall consider such rate appeals within a reasonable period. After April first, nineteen hundred ninety-six, through March thirty-first, nineteen hundred ninety-seven, the commissioner shall revise certified rates of payment not to exceed an aggregate payment of forty-seven million dollars, state share medical assistance.

16. Notwithstanding any inconsistent provision of law or regulation to the contrary, residential health care facility rates of payment determined pursuant to this article for governmental agencies for services provided on or after April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six, shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(a) an aggregate reduction shall be calculated for each residential health care facility commencing April first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand three and on and after April first, two thousand three through March thirty-first, two thousand six and on and after April first, two thousand six through December thirty-first, two thousand six as the result of (i) fifty-six million dollars on an annualized basis multiplied by (ii) the ratio of patient days for patients eligible for payments made by governmental agencies provided in a base year two years prior to the rate year by a residential health care facility, or for residential health care facility beds not fully in operation in such base year by an estimate of projected utilization for the rate year, divided by the total of such patient days summed for all residential health care facilities; and

(b) the result for each residential health care facility shall be divided by such patient days provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

17. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April first, nineteen hundred

ninety-seven through March thirty-first, nineteen hundred ninety-eight, the commissioner shall not be required to revise a certified rate of payment established pursuant to this article based on consideration of rate appeals filed by a residential health care facility or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article. For the period April first, nineteen hundred ninety-eight, through March thirty-first, nineteen hundred ninety-nine, the commissioner shall revise certified rates of payment in an aggregate amount not to exceed twenty million dollars, state share medical assistance. In cases where the commissioner determines that a significant financial hardship exists, he or she may, subject to the approval of the director of the budget, consider an exemption to this subdivision. Beginning April first, nineteen hundred ninety-nine and thereafter, the commissioner shall consider such rate appeals within a reasonable period.

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal years beginning April first, two thousand ten and ending March thirty-first, two thousand twenty-nine, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand twenty-nine, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such

negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand twenty-nine. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

(c) Notwithstanding any other contrary provision of law, rule or regulation, for periods on and after April first, two thousand eleven the commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing priorities and time frames for processing rate appeals, including rate appeals filed prior to April first, two thousand eleven, within available administrative resources; provided, however, that such regulations shall not be inconsistent with the provisions of paragraph (b) of this subdivision.

17-a. Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January first, nineteen hundred ninety-eight, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either nineteen hundred eighty-three, nineteen hundred eighty-seven or nineteen hundred ninety-three calendar year financial and statistical data and for periods beginning April first, two thousand four through March thirty-first, two thousand nine based on either nineteen hundred eighty-three, nineteen hundred eighty-seven, nineteen hundred ninety-three or two thousand one calendar year financial and statistical data; provided, however, the state share amount for the utilization of two thousand one calendar year data shall be no more than twenty-two million dollars on a pro rata basis per calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of

any of the other three years' data. Such methodology shall utilize the nineteen hundred eighty-three and nineteen hundred eighty-seven regional direct and indirect input price adjustment factor corridor percentages in existence on January first, nineteen hundred ninety-seven as well as nineteen hundred ninety-three regional direct and indirect input price adjustment factor corridor percentage in existence on January first, two thousand four as well as a two thousand one regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the nineteen hundred ninety-three direct and indirect input price adjustment factor corridor percentages in existence on January first, two thousand four; provided, however, for rate periods on and after April first, two thousand nine, the regional input price adjustment factors shall be based on the case mix predicted staffing for registered nurses, licensed practical nurses, nurses' aides, licensed therapists and therapist aides. For the rate period beginning April first, two thousand nine through the day immediately prior to the day the provisions of subdivision two-c of this section take effect, the regional direct and indirect input price adjustment factors to be applied to a facility's rate calculation shall be based upon the utilization of two thousand two calendar year financial and statistical data. Such methodology shall utilize two thousand two regional direct and indirect input price adjustment factor corridor percentages calculated in the same manner as the two thousand one regional direct and indirect input price adjustment factor corridor percentages in existence on December thirty-first, two thousand six except that every region shall receive a corridor to reflect the region's actual variation subject to a maximum statewide average variable corridor percentage of ten percent.

18. Residential health care facility recruitment and retention of health care workers. Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation:

(a) (i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this article for non-public residential health care facilities in accordance with subparagraph (ii) of this paragraph for purposes of recruitment and retention of health

care workers in the following aggregate amounts for the following periods:

(A) fifty-three million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eighty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; one hundred fifteen million eight hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; fifty-seven million nine hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty-seven million nine hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and fifty-nine million four hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such increases shall be allocated proportionally based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF - 4 cost report or exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one, where applicable, to the total of such reported costs for all non-public residential health care facilities, provided, however, that for periods on and after July first, two thousand seven, fifty percent of such increases shall be allocated proportionally, based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the nineteen hundred ninety-nine RHFC - 4 cost report or exhibit 11 of the nineteen hundred ninety-nine institutional cost report submitted to the department prior to November first, two thousand one, where applicable, to the total of such reported costs for all non-public residential health care facilities, and fifty percent of such increases shall be allocated proportionately, based on each such non-public facility's reported Medicaid revenue, as reported in the applicable two thousand five cost report as submitted to the department prior to November first, two thousand six, to the total of such Medicaid revenue reported by all such non-public facilities. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient

rates of payment established pursuant to this article for non-public residential health care facilities, based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(b) (i) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent provision of law, the commissioner shall make grants to public residential health care facilities without a competitive bid or request for proposal process for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) seven million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; and eight million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, eight million one hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, six million six hundred ninety thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such grants shall be allocated proportionally based on each public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF - 4 cost report or exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one, where applicable, to the total of such reported costs for all public residential health care facilities.

(c) (i) Non-public and public residential health care facilities in operation as of the effective date of this paragraph which have not submitted 1999 RHCF-4 cost reports or 1999 institutional cost reports but which have submitted such reports for cost years subsequent to 1999,

shall have distributions authorized in subparagraph (i) of paragraph (a) of this subdivision or in subparagraph (i) of paragraph (b) of this subdivision allocated based on total gross salary and fringe benefit costs on exhibit H of the earliest subsequently submitted RHCF-4 cost report or exhibit 11 of the earliest subsequently submitted institutional cost report, as trended downward to 1999 using trend factors authorized in accordance with the provisions of section twenty-one of chapter one of the laws of nineteen hundred ninety-nine.

(ii) Non-public and public residential health care facilities in operation as of the effective date of this paragraph which have not submitted 1999 or subsequent RHCF-4 cost reports or institutional cost reports, shall have distributions authorized in subparagraph (i) of paragraph (a) of this subdivision or in subparagraph (i) of paragraph (b) of this subdivision allocated based on imputed total gross salary and fringe benefit costs reflecting the average of such costs in the region in which each such facility is located, provided, however, that for periods on and after July first, two thousand seven, facilities that have not submitted two thousand five cost reports shall have distributions allocated based on imputed days of care to patients eligible for medical assistance, reflecting the average of such medicaid days of care in the region in which such facilities are located.

(iii) Non-public and public residential health care facilities which received allocations pursuant to subparagraph (ii) of this paragraph and which subsequently submit RHCF-4 cost reports or institutional cost reports shall, for the purpose of setting medical assistance rates of payment, have such allocations adjusted to reflect costs which were incurred in connection with such allocations and which are contained in such cost reports.

(d) Residential health care facilities which have their rates adjusted or receive grants pursuant to paragraphs (a), (b) and (c) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such residential health care facility shall submit, at a time and in a manner to be determined by the commissioner, a written

certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each residential health care facility to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

(e) Residential health care facilities which have their rates adjusted or receive grants pursuant to paragraphs (a), (b) and (c) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such residential health care facility shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each residential health care facility to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

19. Notwithstanding any law, rule or regulation to the contrary, the commissioner shall within amounts allocated pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this article, make adjustments to the medical assistance rates of payment to residential health care facilities to assist certain financially

disadvantaged nursing homes, in order to promote financial stability and quality improvement. Such adjustments shall be made pursuant to subdivision twenty-one of this section.

20. a. The commissioner shall timely develop and implement a standardized process for assessing the feasibility of capital mortgage re-financings, including a standard formula for determining the net cost benefit of re-financing, inclusive of all transaction and closing costs. On or before September first, two thousand three or thirty days after the commissioner makes the standard formula available to facilities, each residential health care facility established under this article and certified as a provider pursuant to title XIX of the federal social security act (Medicaid), except for those facilities established under the nursing home companies law or the hospital loan construction law, shall review its existing capital debt structure using the standard formula to evaluate whether or not a material cost benefit could be derived by re-financing its capital mortgage or mortgages, and shall forward the results of such review to the commissioner. The commissioner may request and such facilities shall submit descriptions of existing mortgage arrangements and debt service reserve funds as needed to implement paragraph b of this subdivision. Facilities established under the nursing home companies law or the hospital loan construction law shall submit to the dormitory authority, the housing finance agency and/or the state of New York mortgage agency such information as is required by such agency to evaluate potential re-financing of such capital mortgages.

b. the commissioner shall review each facility's submission and make a written determination as to whether or not the facility should re-finance its capital mortgage or mortgages, and if so, for what amount, within sixty days of the date of the facility's submission based on the following parameters:

(i) the mortgage re-financing must result in a present value cost benefit that "materially exceeds", as such term is defined by the commissioner, the amount of all transaction and closing costs associated with the re-financing, including any pre-payment penalties associated with the current mortgage or mortgages. The commissioner shall do such

calculations in a manner consistent with comparable calculations in the state finance law;

(ii) mortgages may be re-financed for a term greater than the remaining term of the existing debt within certain limits, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph;

(iii) mortgages may be re-financed utilizing variable rate mortgage loans, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph. In such cases, for purposes of determining the reimbursable capital interest expense included in the capital cost component of rates of payment determined pursuant to this article, the average interest rate over the life of the re-financed mortgage shall not exceed the interest rate in effect on the previous mortgage debt immediately prior to the re-financing;

(iv) not-for-profit and governmental residential health care facilities may utilize taxable mortgage loans to re-finance their existing debts, if doing so would result in the present value cost benefit specified in subparagraph (i) of this paragraph;

(v) moneys contained in facility debt service reserve funds may be considered in the evaluation of amounts necessary to be re-financed, but only to the extent such moneys total more than the debt service reserves needed to establish the successor capital mortgage financing;

(vi) in no event shall funded depreciation accounts, or building funds accumulated through donor-restricted contributions or unrestricted contributions, gifts, bequests, or legacies, be considered in the evaluation of amounts necessary to be re-financed; and

(vii) notwithstanding any inconsistent provision of law or regulation to the contrary, the principal amount, including all transaction and closing costs and any pre-payment penalties associated with the previous mortgage or mortgages, that is thereby deemed necessary to be re-financed by the commissioner, as approved by the public authorities control board and the United States department of housing and urban development where appropriate, shall be considered the final, approved mortgage amount for capital cost reimbursement under the relevant provisions of this article.

c. Notwithstanding any inconsistent provision of law or regulation to

the contrary, the capital cost component of rates of payment for services provided for the period beginning October first, two thousand three or one hundred eighty days after the effective date of this subdivision, whichever is later, through March thirty-first, two thousand four for residential health care facilities established under this article and certified as providers pursuant to title XIX of the federal social security act (Medicaid), except for those facilities established under the nursing home companies law or the hospital loan construction law, that have been identified by the commissioner as refinancing candidates pursuant to paragraph b of this subdivision shall reflect capital interest costs equivalent to the lower of the prevailing market borrowing rates available on or about July first, two thousand three or ninety days after the effective date of this subdivision, whichever is later, for refinancing capital mortgages for their remaining term plus two hundred basis points, or the existing rate being paid by the facility on its capital mortgage or mortgages as of that date. The commissioner shall determine, in consultation with mortgage financing experts, the prevailing market borrowing rates available to not-for-profit and governmental residential health care facilities to re-finance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to re-finance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to re-finance capital mortgages on a taxable fixed rate basis, for this purpose. Exceptions to this policy shall be provided by the commissioner to each such facility that demonstrates, prior to October first, two thousand three or thirty days after receipt of the commissioner's written determination specified in paragraph (b) of this subdivision, whichever occurs later, that:

(i) it has initiated or completed the process of re-financing the mortgage or mortgages in question, in which case the capital cost component of rates of payment shall be timely revised to reflect capital interest costs associated with a re-financed mortgage that conforms to the standards in paragraph (b) of this subdivision. For this purpose, a facility that has applied for approval by the commissioner, the state hospital review and planning council and/or the public health council to re-finance its existing mortgage debt as part of a larger project involving facility replacement, expansion, renovation or change of

ownership is considered to have initiated the process of re-financing;
or

(ii) it can not re-finance its capital mortgage or mortgages to achieve the relevant present value cost benefit specified in subparagraphs (i) and (ii) of paragraph (b) of this subdivision due to a "lock out" or similar provision in its current mortgage agreement that prevents re-financing; due to some other type of genuine re-financing obstacle, such as an inability of the facility to obtain credit approval from a lender or mortgage insurer, or due to an intervening change in credit market conditions or other relevant circumstances, in which case the capital cost component of rates of payment shall continue to reflect capital interest costs associated with the existing mortgage or mortgages, together with reasonable costs incurred in connection with the facility's attempt to re-finance its existing mortgage debt.

d. Notwithstanding any contrary provision of law, rule or regulation, for rate periods on and after April first, two thousand eleven, the commissioner may reduce or eliminate the payment factor for return on or return of equity in the capital cost component of Medicaid rates of payment for services provided by residential health care facilities, and for rate periods on and after April first, two thousand twenty, there shall be no payment factor for residual equity reimbursement in the capital cost component of Medicaid rates of payment for services provided by residential health care facilities.

e. Notwithstanding any other provision of law or regulation to the contrary, the commissioner shall adopt or amend on an emergency basis any regulation the commissioner determines necessary to implement any provision of this subdivision.

21. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five through

April thirtieth, two thousand eleven and on and after May first, two thousand twelve, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, provided, however, that public residential health care facilities shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April first, two thousand nine, provided further, however, that notwithstanding any contrary provision of law and subject to the availability of federal financial participation, each facility that receives a rate adjustment pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven shall have its medicaid rates reduced for the rate period December first, two thousand eleven through December thirty-first, two thousand eleven by an amount equal in aggregate to the aggregate amount of the funds such facility received pursuant to this subdivision for the period May first, two thousand ten through April thirtieth, two thousand eleven.

(b) Eligibility for such rate adjustments shall be determined on the basis of each residential health care facility's operating margin over the most recent three-year period for which financial data are available from the RHCF-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October first, two thousand four through December thirty-first, two thousand four, financial information for the calendar years two thousand through two thousand two shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.

(c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based residential health care facilities for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the

magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three year period, or an average Medicaid utilization percentage of fifty percent or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this subdivision, provided, however, that for rate periods on and after April first, two thousand nine, such disqualification:

- (i) shall not be applied solely on the basis of a facility's having a positive total margin in the most recent year of such three-year period;

- (ii) shall be extended to those facilities in the quartile of facilities with the second smallest negative operating margins; and

- (iii) shall also be extended to those facilities with an average Medicaid utilization percentage of less than seventy percent during the most recent year of the three-year period.

- (d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this subdivision, the commissioner shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three, provided, however, that for periods on and after April first, two thousand nine, the amount of such average annual operating loss shall be reduced by an amount equal to the amount received by such facility pursuant to subparagraph (ii) of paragraph (a) of subdivision two-b of this section. For this purpose, for hospital-based residential health care facilities for which the average annual operating loss cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the residential health care facility based on the proportion the residential health care facility's total revenues for the period bears to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss shall then be reduced by an amount equal to the amount received by such facility pursuant to subparagraph (ii) of paragraph (a) of subdivision two-b of this section.

(e) For periods prior to April first, two thousand nine, each such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this subdivision by the applicable percentage shown in the tables below for the quartile within which the facility's negative operating margin for the three-year period is assigned.

i. For a facility located in a county with a total population of two hundred thousand or more as determined by the two thousand U.S. Census:
First Quartile (lowest operating margins): 30 percent

Second Quartile: 15 percent

Third Quartile: 7.5 percent

ii. For a facility located in a county with a total population of fewer than two hundred thousand as determined by the two thousand U.S. Census:
First Quartile (lowest operating margins): 35 percent

Second Quartile: 20 percent

Third Quartile: 12.5 percent

(f) The amount of any facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision shall be reduced by the facility's estimated rate year benefit of the two thousand one update to the regional input price adjustment factors authorized pursuant to former subdivision seventeen of this section as amended by section 24 of part C of chapter 58 of the laws of 2004, or as authorized by subdivision seventeen-a of this section, as added by section 56 of part C of chapter 58 of the laws of 2007, if any, provided, however, that such reduction shall not be applied with regard to rate periods on and after April first, two thousand nine. After all other adjustments to a facility's financially disadvantaged residential health care facility distribution have been made in accordance with this subdivision, the amount of each facility's distribution shall be limited to no more than four hundred thousand dollars during the period October first, two thousand four through December thirty-first, two thousand four and, on an annualized basis, for rate periods through March thirty-first, two thousand nine, and no more than one million dollars for the period April first, two thousand nine through December thirty-first, two thousand nine and for each

annual rate period thereafter.

(g) The adjustment made to each qualifying facility's medical assistance rate of payment determined pursuant to this article shall be calculated by dividing the facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision by the facility's total medical assistance patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October first, two thousand four through December thirty-first, two thousand four shall be calculated based on twenty-five percent of each facility's reported total medical assistance patient days as reported in the applicable two thousand two cost report. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged residential health care facility rate adjustments to eligible facilities for a rate period in accordance with this subdivision shall be thirty million dollars for the period October first, two thousand four through December thirty-first, two thousand four and thirty million dollars on an annualized basis for rate periods on and after January first, two thousand five through December thirty-first, two thousand eight and thirty million dollars on an annualized basis on and after January first, two thousand nine, provided that, subject to all necessary federal approvals, on and after January first, two thousand thirteen funds allocated under this paragraph shall be distributed pursuant to 10 NYCRR 86-2.39. The nonfederal share of such rate adjustments shall be paid by the state, with no local share, from allocations made pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this article. In the event the statewide total of the annual rate adjustments determined pursuant to paragraph (g) of this subdivision varies from the amounts set forth in this paragraph, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the total of the annual rate adjustments made pursuant to this subdivision is equal to the amounts set forth in this paragraph on a statewide basis.

(i) This subdivision shall be effective if, and as long as, federal

financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate adjustments determined in accordance with this subdivision.

(j) For periods on and after April first, two thousand nine, residential health care facilities which are otherwise eligible for rate adjustments pursuant to this subdivision shall also, as a condition for receipt of such rate adjustments, submit to the commissioner a written restructuring plan that is acceptable to the commissioner and which is in accord with the following:

(i) such an acceptable plan shall be submitted to the commissioner within sixty days of the facility's receipt of rate adjustments pursuant to this subdivision for a rate period subsequent to March thirty-first, two thousand eight, provided, however, that facilities which are allocated four hundred thousand dollars or less on an annualized basis shall be required to submit such plans within one hundred twenty days, and further provided that these periods may be extended by the commissioner by no more than thirty days, for good cause shown; and

(ii) such plan shall provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and shall include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan; and

(iii) such plan shall require periodic reports to the commissioner, in accordance with a schedule acceptable to the commissioner, setting forth the progress the facility has made in implementing its plan; and

(iv) such plan may include the facility's retention of a qualified chief restructuring officer to assist in the implementation of the plan, provided, however, that this requirement may be waived by the commissioner, for good cause shown, upon written application by the facility.

(k) If a residential health care facility fails to submit an acceptable restructuring plan in accordance with the provisions of paragraph (j) of this subdivision, the facility shall, from that time forward, be precluded from receipt of all further rate adjustments made pursuant to this subdivision and shall be deemed ineligible from any future re-application for such adjustments. Further, if the commissioner

determines that a facility has failed to make substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the commissioner may, upon thirty days notice to that facility, disqualify the facility from further participation in the rate adjustments authorized by this subdivision and the commissioner may require the facility to repay some or all of the previous rate adjustments.

22. Nursing home incentives for improved performance in patient care. Pursuant to such program, and within amounts as are appropriated therefor, the commissioner shall investigate adjusted quality indicators and quality measures including those defined by the federal centers for medicare and medicaid service (CMS) with respect to nursing home quality and quality benchmarks. The commissioner shall award rate enhancements to those residential health care facilities who demonstrate to the satisfaction of the commissioner, they can meet or exceed such defined quality measures. Such quality measures may include, but not be limited to, outcomes from state survey data, performance measures, and resident outcomes based upon Minimum Data Sets as defined by CMS. The commissioner shall consult with associations representing residential health care facilities and associations representing nursing home residents, and shall by July first, two thousand seven, adopt rules and regulations that incorporate payment incentives, related to such quality indicators and measures, including, but not limited to programs to improve patient care outcomes and performance outcomes. Such programs may include but not be limited to, clinician-centric electronic medical records implementation, automation of assessments and care plans, improved data collection, and the provision of accessible consumer information as well as patient satisfaction, into rates of payment.

22-a. Modifications. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective April first, two thousand six and thereafter, residential health care facility rates of payment determined pursuant to this section for payments made by governmental agencies shall not contain a payment factor for interest on current indebtedness if the residential health care facility cost report utilized to determine such payment factor also shows a withdrawal of

equity, a transfer of assets, or a positive net income.

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for residential health care facility rates of payment determined pursuant to this article for services provided on and after April first, two thousand six, the annual cost report filed by each residential health care facility for two thousand five and for each year thereafter shall be examined and in the event the operating costs reported by each such facility in any such cost report is less than ninety percent of the operating costs reported in the cost report which is being utilized to set such facility's existing rates of payment trended to two thousand five and each year thereafter, then such rates of payment shall be recalculated utilizing the more recent reported operating cost data.

(c) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective on and after April first, two thousand six, for purposes of establishing rates of payment by governmental agencies for residential health care facilities licensed pursuant to this article, the operating component of the rate for any residential health care facility that did not or does not achieve ninety percent or greater occupancy for any year within five calendar years from the date of commencing operation, shall be recalculated utilizing the facility's most recently available reported allowable costs divided by patient days imputed at ninety percent occupancy. Such recalculated rates of payment shall be effective January first of the sixth calendar year following the date the facility commenced operations or April first, two thousand six, whichever is later.

(d) (i) Notwithstanding any inconsistent provisions of subdivisions two-b or two-c of this section or any other contrary provision of law, and subject to the availability of federal financial participation, for inpatient services provided by residential health care facilities on and after April first, two thousand eleven, the commissioner may, subject to the approval of the director of the budget, grant approval of a temporary adjustment to Medicaid rates for eligible facilities, as determined in accordance with this paragraph.

(ii) Eligible facilities shall be those residential health care facilities which, as determined by the commissioner, require short-term assistance to accommodate additional patient services requirements

stemming from the closure of other facilities in the area, including, but not limited to, additional staff, service reconfiguration and enhanced information technology capability.

(iii) Eligible facilities shall submit written proposals demonstrating the need for additional short-term resources and how such additional resources will result in improvements to:

(A) the cost effectiveness of service delivery;

(B) quality of care; and

(C) other factors deemed appropriate by the commissioner.

(iv) Such written proposals shall be submitted to the department at least sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of time as determined by the commissioner. At the end of the specified timeframe, the facility will be reimbursed in accordance with otherwise applicable rate-setting methodologies. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in accordance with the facility's approved proposals and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

23. Notwithstanding any inconsistent provision of law or regulation to the contrary:

(a) (i) For adult day health care services provided by residential health care facilities, effective April first, two thousand seven and thereafter, the operating component of the rate of payment established pursuant to this article for an adult day health care program which has achieved an occupancy percentage of ninety percent or greater for a calendar year prior to April first, two thousand seven, shall be calculated utilizing allowable costs reported in the two thousand four, two thousand five, or two thousand six calendar year residential health care facility cost report filed by the sponsoring residential health care facility, whichever is the earliest of such calendar year cost

reports in which the program has achieved an occupancy percentage of ninety percent or greater, except that programs receiving rates of payment based on allowable costs for a period prior to April first, two thousand seven shall continue to receive rates of payment based on such period.

(ii) For such programs which achieved an occupancy percentage of ninety percent or greater prior to calendar year two thousand four, so long as approved capacity in that year is the same as in calendar year two thousand four, but which did not maintain occupancy of ninety percent or greater in calendar years two thousand four, two thousand five, or two thousand six, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the two thousand four calendar year cost report divided by visits imputed at ninety percent occupancy.

(iii) For such programs which have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to April first, two thousand seven, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the first calendar year after two thousand six in which such a program achieves an occupancy percentage of ninety percent or greater effective January first of such calendar year except for calendar year two thousand seven, effective no earlier than April first of such year, provided, however, that effective January first, two thousand nine, for programs that have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to January first, two thousand nine, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the two thousand nine cost report filed by the sponsoring residential health care facility divided by visits imputed at actual or ninety percent occupancy, whichever is greater. This subparagraph shall also apply to programs which achieved an occupancy percentage of ninety percent or greater prior to calendar year two thousand four but in such year had an approved capacity that was not the same as in calendar year two thousand four.

(b) For a residential health care facility approved to operate an adult day health care program on or after April first, two thousand

seven, rates of payment for such programs shall be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility, and total estimated annual visits by adult day health care registrants of not less than ninety percent of licensed occupancy, and in accordance with the following:

(i) Each program shall be required to submit an individual budget. Multiple programs operated by the same residential health care facility shall submit a separate budget for each program. Multiple programs operated by the same residential health care facility shall have separate rates of payment.

(ii) Rates developed based upon budgets shall remain in effect for no longer than two calendar years from the earlier of:

(A) the date the program commences operations; or

(B) the date the sponsoring residential health care facility submits a full calendar year residential health care facility cost report in which the program has achieved ninety percent or greater occupancy. If a sponsoring residential health care facility submits such a cost report within two years of the date the program commences operation, rates shall then be computed utilizing such cost report.

(iii) If a program fails to achieve ninety percent or greater occupancy within two calendar years of the date of its commencing operations, rates shall be calculated utilizing allowable costs reported in such second calendar year residential health care facility's cost report for the applicable sponsoring residential health care facility divided by visits imputed at ninety percent occupancy.

(c) Effective January first, two thousand eight, allowable costs shall not include the costs of transportation.

(d) All rates of payment established pursuant to this subdivision are subject to the maximum daily rate provided by law. Such maximum daily rate of payment for adult day health care programs operated by residential health care facilities that undergo a change of ownership subsequent to nineteen hundred ninety shall be determined by utilizing the inpatient rate of payment of the prior operator as in effect on January first, nineteen hundred ninety. In the event a residential health care facility establishes an off-site adult day health care program outside the regional input price adjustment region in which it is located, the computation of the maximum daily rate of payment for

such program shall utilize the weighted average of the inpatient rates of payments for residential health care facilities in the region in which the program is located, as in effect on January first, nineteen hundred ninety, in place of the sponsoring residential health care facility's inpatient rate of payment.

(e) Notwithstanding any inconsistent provision of the state administrative procedure act or any other law or regulation to the contrary, the commissioner shall adopt or amend on an emergency basis any regulations the commissioner shall determine necessary to implement any provision of this subdivision.

24. Notwithstanding any other provisions of this section and any other law, rule or regulation to the contrary, for periods on and after July first, two thousand seven, the operating component of all rates of payment made by governmental agencies for services to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law and provided by a residential health care facility with fewer than sixty beds as of July first, two thousand seven, which provides services primarily to neurologically impaired individuals and is located in a county with a population between two hundred ninety thousand and three hundred ten thousand as of July first, two thousand seven shall be based solely on the methodology used to establish rates for facilities which provide extensive nursing, medical, psychological and counseling support services solely to children; provided, however, this subdivision shall not apply if the application would result in a lesser rate of payment than otherwise provided for under this section. Nothing in this subdivision shall be construed to limit the application to such facility of rate adjustments applied to other residential health care facilities.

25. Reserved bed days. (a) For purposes of this subdivision, a "reserved bed day" is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance pursuant to title eleven of article five of the social services law while he or she is on therapeutic leave of absence from the facility.

(b) Notwithstanding any other provisions of this section or any other

law or regulation to the contrary, for reserved bed days provided on behalf of persons twenty-one years of age or older:

(i) payments for reserved bed days shall be made at ninety-five percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of such person; and

(ii) payment to a facility for reserved bed days provided on behalf of such person for therapeutic leaves of absence may not exceed ten days in any twelve month period.

25-a. Reserved bed days for state veterans' homes. (a) For purposes of this subdivision, a "reserved bed day" is a day for which the state pays New York State Veterans' Home at Oxford, the New York State Veterans' Home at St. Albans, the New York State Veterans' Home at Batavia, the New York State Veterans' Home at Montrose or the Long Island State Veterans' Home to reserve a bed for a person eligible for medical assistance pursuant to title eleven of article five of the social services law while he or she is temporarily hospitalized.

(b) (i) Payments for reserved bed days shall be made at fifty percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of the person.

(ii) Payment to a facility for reserved bed days provided on behalf of the person for temporary hospitalizations may not exceed fourteen days in any twelve-month period.

(iii) The person must have resided in the applicable State Veterans' home for at least thirty days since the date of his or her initial admission.

(iv) Unless medically contraindicated, the applicable State Veterans' home shall reserve the same bed and room the person occupied before being hospitalized or placed on a therapeutic leave of absence.

(v) Reserved bed days under this subdivision are in addition to reserve bed days for therapeutic leave of absence under subdivision twenty-five of this section.

(vi) This subdivision shall apply subject to the availability of federal financial participation.

26. Notwithstanding any inconsistent provision of law, for rate periods on and after April first, two thousand ten, residential health

care facility Medicaid rates of payment shall not include reimbursement for the cost of prescription drugs. Such reimbursement shall be in accordance with otherwise applicable provisions of section three hundred sixty-seven-a of the social services law.

* 27. The commissioner is authorized to conduct an energy audit and/or disaster preparedness review of residential health care facilities. Such audit or review shall explore the energy efficiency and/or disaster preparedness of the real property capital aspects of each facility and develop a cost/benefit analysis of potential modifications for each facility. Such audit or review shall serve as the basis for an energy efficiency and/or disaster preparedness program to be developed by the department in regulations. Participation in such audit or review shall be a condition to participation in any such program developed as a result thereof, and shall also be a condition to receipt of any funding available under such program. Such program shall only be implemented if it is in the best financial interests of the state, as determined by the commissioner. At least forty-five days prior to implementing such program, the department shall report to the senate and assembly health committees, the assembly ways and means committee and the senate finance committee the results of the energy audit authorized herein and the proposed eligibility criteria, funding sources, the manner in which savings may be shared between the state and facilities and any other information requested by such committees about such program prior to the transmittal of the report.

* NB Repealed July 1, 2027

§ 2808-a. Liability of certain persons. 1. Every person who is a controlling person of any residential health care facility liable under any provision of this article to any person or class of persons for damages or to the state for any civil fine, penalty, assessment or damages, shall also be liable, jointly and severally, with and to the same extent as such residential health care facility, to such person or class of persons for damages or to the state for any such civil fine, penalty, assessment or damages.

2. For purposes of this section, a "controlling person" of a

residential health care facility shall be deemed to mean any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility. Neither the commissioner nor any employee of the department nor any member of a local legislative body of a county or municipality, nor any county or municipal official except when acting as the administrator of a residential health care facility, shall, by reason of his or her official position, be deemed to be a controlling person of any residential health care facility nor shall any person who serves as an officer, administrator or other employee or as a member of a board of directors or trustees of any facility be deemed to be a controlling person of said facility as a result of such position or his or her official actions in such position.

§ 2808-b. Certification of financial statements and financial information. 1. All financial statements or financial information required by law or regulation to be submitted by a nursing home or facility providing health-related service shall be certified in their entirety by an independent certified public accountant or independent public accountant. The commissioner shall by regulation establish the form of certification which shall ensure that the certified public accountant or public accountant:

(a) has disclosed any and all material facts known to him, disclosure of which is necessary to make the financial statements or financial information not misleading; and

(b) during the period of his professional engagement, at the time of expressing his opinion, or during the period covered by the financial statements, did not have nor was committed to acquire, any direct financial interest or material indirect financial interest in the ownership or operation of the nursing home or facility; and

(c) during the period of his professional engagement, at the time of expressing his opinion or during the period covered by the financial statements, was not connected in any way with the ownership, financing or operation of the nursing home or facility as a director, officer or employee, or in any capacity other than as an independent certified

public accountant or independent public accountant; and

(d) subsequent to such certification discloses any material fact discovered by him which existed at the time of such certification and was not disclosed in the financial statements or financial information, the disclosure of which is necessary to make the financial statements or financial information not misleading and discloses any material misstatement in said financial statements or financial information.

2. Any person submitting a financial statement or financial information which he knows to be false or certifying a financial statement or financial information which he knows to be false shall be guilty of a class E felony.

*** § 2808-c. Reimbursement of general hospital inpatient services.** 1. General hospital rates and inpatient revenue cap. In determining payments from all sources for general hospital inpatient services for the rate year commencing on January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty-three, the allowances set forth in subdivision four of this section shall be included. Effective January first, nineteen hundred eighty-four, the commissioner shall establish, in accordance with regulations adopted by the council and approved by the commissioner, the maximum amount of inpatient revenue a general hospital will be authorized to receive for services during a designated period not to exceed twelve months from all payors for the provision of inpatient services. This maximum amount will be known as the inpatient revenue cap and shall be established for each general hospital possessing a valid operating certificate issued pursuant to section twenty-eight hundred five of this article. The inpatient revenue cap shall be established by projecting to anticipated expense levels the reimbursable historical inpatient expenses and financial needs as defined in subdivision four of this section, of a general hospital approved for financing through inpatient service revenues. Expenses included in the inpatient revenue cap are those determined to be allowable and reasonable in the provision of authorized inpatient services.

The inpatient revenue caps for the rate years nineteen hundred eighty-four and nineteen hundred eighty-five shall be determined by computing an imputed revenue cap for the period beginning January first, nineteen hundred eighty-three and ending December thirty-first, nineteen hundred eighty-three, which has been based on the cost analysis pursuant to paragraphs (a) and (b) of subdivision two of this section and adjusted each year to reflect the trend factors developed and applied in accordance with paragraph (e) of subdivision two of this section, capital related expenses in accordance with paragraph (c) of subdivision two of this section, redetermination of additional financial needs or revenue requirements in accordance with paragraph (d) of subdivision two of this section, adjustments made in accordance with subdivision five of this section and adjustments to reflect audit findings.

Hospital inpatient services to patients who are not beneficiaries or subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, subchapter XVIII of the federal social security act (medicare), eligible for payments made by state governmental agencies, enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter, or enrolled in a self-insured and self administered group covered under the provisions of subdivision six of this section shall be at charges established by the hospital in accordance with the provisions of subdivision six of this section with the exception that for the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-three rates of payment pursuant to the provisions of the workers' compensation law, the volunteer firemen's benefit law and the comprehensive automobile insurance reparations act shall be established at one hundred twelve percent of trended average per diem reimbursable cost including allowances as specified in subdivision four of this section.

Amounts prospectively established for payments for general hospital inpatient services provided in rate years subsequent to nineteen hundred eighty-three made on behalf of subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, beneficiaries of subchapter XVIII of the federal social security act

(medicare), eligibles for payments made by state governmental agencies and those enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter shall be based on that portion of the prospectively established inpatient revenue cap that is related to the utilization of inpatient services by the above programs, provided, however, that that share of the cost of bad debt and charity care to be paid under subchapter XVIII of the federal social security act shall be based upon the ratio of subchapter XVIII inpatient charges to total inpatient and outpatient charges, except for hospitals using an all inclusive rate, in which case the subchapter XVIII share shall be based upon the ratio of subchapter XVIII inpatient cost to total inpatient and outpatient hospital costs. After reducing the dollar amount liability of all payors by subtracting the dollar amount liability of the subchapter XVIII payor, all other payors shall pay the remaining liability in proportion to the ratio of their hospital inpatient charges to total hospital inpatient charges less the subchapter XVIII inpatient charges. These proportions shall be computed on the basis of costs for hospitals using an all inclusive rate.

Any adjustments in the overall revenue cap in accordance with subdivision five of this section shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs. The year end adjustment as provided for in paragraph (d) of subdivision five of this section which is based on data contained in the financial and statistical report filed for the effective year of the revenue cap may be further adjusted within the revenue cap when actual data indicates a change in payor utilization and cost apportionment between and among the above specified programs and all other payors. After such adjustments the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs shall constitute guaranteed revenue to the general hospital. Nothing in this section shall prohibit the negotiation by health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, of agreements with general hospitals for rates of payment other than those provided herein. Such contracts shall require approval by the commissioner and

must include provision for special benefit packages or arrangements for providing inpatient services to encourage patient management behavior that will minimize the length of patient stay, such as special admission arrangements, bed leasing or other inpatient capitation arrangements.

2. The inpatient revenue cap established shall include:

(a) allowable historical inpatient operational expenses which are comparable in nature and can reasonably be expected to be comparable in amount to other general hospitals with similar cost influencing characteristics (adjusted for comparison purposes for differences in wage and fringe benefit levels) and which are equal to or less than reasonable reimbursable operational cost ceilings developed from the average allowable cost per unadjusted (except for newborn days) appropriate unit of service of all hospitals in the comparison group. The comparison group shall consist of general hospitals sharing similar cost influencing characteristics and classified in accordance with variables defined in regulation;

(b) allowable historical inpatient operational expenses, other than capital related expenses as defined in subdivision three of this section, and other than costs included in paragraph (a) hereof, which may be subject to reasonable reimbursable cost standards adopted by the council and approved by the commissioner;

(c) capital related expenses determined in accordance with subdivision three of this section;

(d) additional financial needs or revenue requirements in accordance with subdivision four of this section;

(e) projection of reimbursable expenses identified through the application of paragraphs (a) and (b) of this subdivision by a trend factor established by the panel of economists as set forth in subdivision eight of this section; and

(f) an amount to reflect anticipated additional revenues resulting from the implementation of the gross charge determination formula provided by the commissioner in accordance with subdivision six of this section.

The establishment of separate rates of payment for patients who require different levels or types of care shall require a reallocation

of costs to insure that the total hospital inpatient revenue cap (or in the case of the period January one, nineteen hundred eighty-three to December thirty-one, nineteen hundred eighty-three the imputed revenue cap), which shall include the revenue for different levels or types of care, established under this subdivision remains unchanged except that adjustments may be made based on the cost analysis pursuant to paragraphs (a) and (b) of this subdivision.

Effective January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-five, the cost limitations, utilization standards and limits on disallowances shall be computed in accordance with the methodology approved by the federal government to permit the determination of all payments for inpatient services provided by general hospitals to be made in accordance with the amendments made to sections twenty-eight hundred seven and twenty-eight hundred seven-a of this chapter by sections three and four of a chapter of the laws of nineteen hundred eighty-two. Specialty hospitals shall not be included in any computations relating to disallowances, limitations or ceilings pursuant to this paragraph but shall receive reimbursement in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner. In order to provide for a transition period for the application of reimbursable cost limitations to payments authorized under subchapter XVIII of the federal social security act, a reasonable phase-in over a three year period is to be implemented.

3. Capital related inpatient expenses. Effective for the year beginning January first, nineteen hundred eighty-four and thereafter, capital related inpatient expenses including but not limited to depreciation, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to that article and article twenty-eight of this chapter, in the case of payments on behalf of other than beneficiaries under subchapter XVIII of the federal social security act), shall be included in the revenue cap on a budget basis, and subsequently reconciled to actual expenses

through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each revenue cap year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital related inpatient expense generated by a capital expenditure which requires or required approval pursuant to this article, must have received such approval for the capital related expense to be included in the revenue cap. The submitted budget may include the capital related inpatient expenses of all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the revenue cap year. Any capital related expense generated by a capital asset acquired or placed in use during a revenue cap year, provided all required approvals pursuant to this article have been obtained, shall be carried forward to the subsequent revenue cap year. In instances where such approvals have been obtained, the budget may include estimates for capital related inpatient expenses. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The council shall adopt, with the approval of the commissioner, regulations to:

- (a) identify by type the eligible capital related inpatient expenses;
- (b) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;
- (c) provide authorization to adjust the inpatient revenue cap by advancing payment of depreciation as needed, in instances of capital debt related financial distress of a voluntary, non-profit general hospital; and
- (d) provide a methodology for the reimbursement treatment of sales.

4. Allowances. Inpatient revenue caps established, or rates for general hospital inpatient services, shall include for the three years commencing on January first, nineteen hundred eighty-three, the allowances specified below in paragraphs (a), (b), (c), (d) and (e) of this subdivision. For the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred

eighty-three the allowances shall be computed on the basis of the general hospital's reimbursable inpatient costs after application of the trend factor. Any additional allowances for the periods January first, nineteen hundred eighty-four through December thirty-first, nineteen hundred eighty-four and from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five shall be included in the certified inpatient revenue caps after application of the trend factor and such adjustments as may be appropriate pursuant to subdivision two of this section. For the purposes of this subdivision and subdivision nine of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(a) For the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-five an allowance of one percent of the general hospital's reimbursable inpatient costs to provide funds to be used at the discretion of hospital governing boards.

(b) For public general hospitals an additional allowance of up to one percent for the second year and up to a further additional one percent in the third year of the three year period commencing January first, nineteen hundred eighty-three subject to the provisions of paragraph (d) of this subdivision.

(c) For voluntary non-profit and private proprietary general hospitals an additional allowance of up to one percent for the second year of the three year period commencing January first, nineteen hundred eighty-three and continued for the third year of the three year period subject to the provisions of paragraph (d) of this subdivision.

(d) The additional allowances in paragraphs (b) and (c) of this subdivision shall be available to general hospitals receiving approval from the commissioner as to the acceptable use of the allowance which uses shall include but be not limited to retirement of short term non-capital debt, meeting costs related to bad debts and charity care not met by the regional pool distributions as specified in subdivision nine of this section, offsetting reductions in anticipated revenue

resulting from charge limits substantially below those applicable to the particular hospital immediately prior to the enactment of subdivision six of this section and needed improvement of current ratio. Allowances authorized in paragraphs (b) and (c) of this subdivision are not to be considered as a substitute for operational funds that are otherwise reimbursable or subject to appeal.

(e) A percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision nine of this section, and within a statewide determination of financial resources to be committed for this purpose. Regional needs shall be equal to the total of inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of general hospitals from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs and revenues and expenses related to the provision of referred ambulatory services. The regional amount to be included in rates approved for the year commencing January first, nineteen hundred eighty-three and in the inpatient revenue caps established in subsequent years for each general hospital in the region will be equal to the result of the application of the percentage of statewide need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals that can be met from available resources computed without consideration of inpatient uncollectible amounts to the regional need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals expressed in dollars plus the dollar amount resulting from the application of the ratio of major public general hospitals inpatient reimbursable costs within the region to total statewide general inpatient reimbursable cost (as computed on the basis of nineteen hundred eighty-one financial and statistical reports) to the statewide resources committed for this purpose computed without consideration of inpatient uncollectible amounts and the ratio of these total dollars to the total regional reimbursable inpatient cost after application of the trend factor. For the three year period commencing on January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred

eighty-five, the percentage allowances for this purpose shall not be less than an average three percent of the total statewide general hospital reimbursable inpatient cost after application of the trend factor. The allocation of resources made available under this paragraph, as specified in subdivision nine of this section, may be changed only as follows: An annual review shall be conducted pursuant to rules and regulations adopted by the council and approved by the commissioner with respect to bad debt and charity care need within each article forty-three insurance law region or such other regions as are adopted pursuant to subdivision nine of this section. If within such a region there is a definitive finding as a result of such review that there has been a change in the proportional amounts of bad debts and charity care provided by (i) major public general hospitals and (ii) voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, the allocation of resources made available under this paragraph shall be adjusted pursuant to the rules and regulations adopted pursuant to this paragraph so as to reflect this change.

(f) An additional allowance of one-fourth of one percent shall be included in each rate or revenue cap established for each voluntary non-profit and private proprietary general hospital to be returned to a regional pool and distributed in accordance with paragraph (c) of subdivision nine of this section.

(g) An additional allowance of one-third of one percent shall be included in each rate or revenue cap established for voluntary non-profit and private proprietary general hospitals to be returned to a regional pool and distributed in accordance with paragraph (d) of subdivision nine of this section.

5. Adjustments. (a) The commissioner shall, on his own initiative, or on the basis of a request from a general hospital, adjust an established inpatient revenue cap to reflect:

(i) the reduction of costs related to the elimination of a general hospital inpatient service in instances where the costs of such service were included in the basis of the inpatient revenue cap established; and

(ii) the correction of errors or omissions of data or in computations.

(b) General hospitals may request and the commissioner shall consider

an adjustment to an established revenue cap to reflect increased expenses or reconsideration of disallowed expenses based on:

- (i) justification of all or a portion of expenses not included in the inpatient revenue cap resulting from the cost analysis process contained in subparagraph (i) of paragraph (a) of this subdivision;

- (ii) additional operational expenses related to construction or service changes. These changes if applicable must be approved under section twenty-eight hundred two of this article;

- (iii) the addition of costs related to a state requirement for additional services to be provided or additional costs to be incurred in meeting state or federal requirements;

- (iv) additional expenses to permit a more efficient and economical method of delivering a service; and

- (v) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established inpatient revenue cap based on a request related to subparagraph (v) of paragraph (b) of this subdivision the commissioner shall consider:

- (i) the fiscal capability of the general hospital to finance such increases from its own resources;

- (ii) the past history of the general hospital with respect to compensation increases and allowed compensation trend factors; and

- (iii) the economy in the area in which the general hospital is located.

(d) The commissioner shall adjust a prospectively established inpatient revenue cap on the basis of subsequent data that demonstrates a significant cost influencing change in patient mix or volume of service. Such adjustment will be made in conformity with regulations adopted by the council as approved by the commissioner.

(e) All appeals shall be submitted to the commissioner, who may submit a copy of the appeal to interested parties for the purpose of providing an opportunity for comment within a specified time period.

(f) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the revenue cap is effective provided that all information necessary to determine whether an adjustment is justified is submitted by the facility prior to May first of such year. In the event

such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

(g) The commissioner shall consider an adjustment to a hospital's reported base year costs in instances where it is demonstrated that recurring costs resulting from multi-year commitments beginning late in a base year should be calculated on an annual basis in establishing a revenue cap in order to avoid a significant inequity. In making such an adjustment the commissioner shall consider the offset of non-recurring base year costs.

6. Hospital charge schedules. Effective for the year beginning January first, nineteen hundred eighty-four and thereafter, each general hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall:

(a) Establish gross charges sufficient to generate the inpatient revenue authorized by the revenue cap; and

(b) Establish gross charges such that (i) the payment rate to be made on behalf of subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients; (ii) permit the continuation of negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred eighty-two; and (iii) for general hospitals subject to the provisions of paragraph (a) or (b) of subdivision twelve of this section, the costs (including all allowances specified in subdivision four of this section) of services provided to charge paying patients shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients.

During the period January first, nineteen hundred eighty-four through December thirty-first, nineteen hundred eighty-five, the discount referred to in subparagraphs (i) and (iii) of paragraph (b) of this subdivision shall not exceed twelve percent for those hospitals which

had a discount of less than twelve percent during the previous year, shall be no greater than the discount in effect during the previous year for those hospitals whose previous year's discount was between twelve and fifteen percent and shall not exceed fifteen percent for all others. Self-insured and self-administered negotiated systems as described in subparagraph (ii) of paragraph (b) of this subdivision may remain in effect for the period commencing January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty-five and shall be incorporated in the formula methodology provided by the commissioner.

The commissioner shall effectuate direct repayment or adjustment of a subsequent inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that exceed the inpatient revenue cap initially established or adjusted in accordance with provisions of this section. Revenue received in excess of the revenue cap established as the result of the provisions of subchapter XVIII of the federal social security act (medicare) phase-in policies or from charges authorized under subdivision seven of this section shall not be included in the adjustment.

7. Working capital. General hospitals may include as a financing or working capital charge an addition of two percent of any valid claim not paid within thirty days of submission or determination of payor liability, whichever is later, and one percent per month thereafter. Revenues received from such financing or working capital charges shall not be included in a revenue cap established or considered as a cost offset. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in a periodic interim payment system.

8. Trend factor. (a) The commissioner in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of charge levels and reimbursement rates in effect until December thirty-first, nineteen hundred eighty-three and the appropriate portion

of the inpatient revenue cap in subsequent years. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner. Not later than September first of each year, the consultants shall provide to the commissioner and the council, the methodology to be used to determine the trend factors for the subsequent twelve month period commencing January first. The commissioner shall monitor the actual price movement during this twelve month period of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants, and shall implement, semi-annually, the recommendations of the consultants for adjustments to the trend factor provided, however, that adjustments, except for the final adjustment in the trend factor shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates or charge limits differing by more than one-half of one percent from that which was previously determined.

9. Bad debt, charity care and transition pool. Regional pools consisting of funds made available within each region through the allowances specified in paragraphs (e), (f) and (g) of subdivision four of this section shall be created. The regions are established as the article forty-three insurance law plan regions, with the exception that the southern sixteen counties will be divided into three regions for the purposes of this subdivision and subdivision four of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur. The commissioner is authorized to contract with the article forty-three insurance law plans to receive funds for

the pools and distribute such funds. In the event contracts with the article forty-three insurance law plans are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of pooled funds and issue an annual report on the receipt and distribution of the pooled funds. In order for general hospitals to participate in the distribution of funds from the pool the general hospital must implement collection policies and procedures approved by the commissioner. Funds available in each regional pool shall be distributed or retained in the following sequence:

(a) Each eligible major public general hospital as defined in subdivision four of this section shall receive from its regional pool created by the allowance in paragraph (e) of subdivision four of this section a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide inpatient reimbursable costs developed on the basis of nineteen hundred eighty-one financial and statistical reports to the total of all regional pools.

(b) Funds remaining in the regional pool created by the allowance in paragraph (e) of subdivision four of this section, after distribution in accordance with paragraph (a) of this subdivision, shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals on the basis of need within the region as determined in accordance with paragraph (e) of subdivision four, with the exception that any funds in a regional pool that were allocated to major public general hospitals and not distributed shall be distributed to each major third party payor on the basis of its percentage of major third party payor liability for bad debt and charity care as described in subdivision one of this section, in the specific major public general hospital to which distribution was not made.

(c) Funds in regional pools created by the allowance in paragraph (f) of subdivision four of this section shall not be available for immediate distribution from the regional pool but shall be retained in the pool for distribution by the commissioner in accordance with rules adopted by the state hospital review and planning council to assist in offsetting losses from bad debts and the costs of charity care of voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance such losses

or costs.

(d) Funds in regional pools created by the allowance in paragraph (g) of subdivision four of this section shall be distributed by including one-fourth of such funds with the funds to be distributed in accordance with paragraph (c) of this subdivision and three-quarters of such funds to be distributed to voluntary non-profit and private proprietary general hospitals within the region that are severely negatively impacted by the inclusion of title XVIII (medicare) patients, or changes in the determination of payor liability, resulting from the implementation of the reimbursement provisions in this section. Rules for such distribution will be those adopted by the state hospital review and planning council and approved by the commissioner.

(e) Any balance in the portion of regional pools created by the allowance in paragraph (e) of subdivision four of this section, after distribution in accordance with paragraph (b) of this subdivision, including income from invested funds, shall be distributed to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals within the region on a basis related to specific hospital need as defined for regional purposes in paragraph (e) of subdivision four of this section. Any balance in the portion of regional pools created by the allowance in paragraph (f) of subdivision four of this section and the distribution specified in paragraph (d) of this subdivision after distribution in accordance with paragraph (c) of this subdivision, including income from invested funds, shall be distributed to voluntary non-profit and private proprietary general hospitals within the region on a basis related to specific hospital need as defined for regional purposes in paragraph (e) of subdivision four of this section. Any balance in the portion of regional pools created by the allowance in paragraph (g) of subdivision four of this section after distribution in accordance with this paragraph and paragraph (d) of this subdivision, including income from invested funds, shall be returned to voluntary non-profit and private proprietary general hospitals on the basis of the reimbursable costs of those hospitals within the region.

10. Unit of service. The unit of general hospital inpatient service on which payment shall be based should be uniform for all payors and shall best identify the cost of services provided.

11. The commissioner shall provide to fiscal intermediaries for subchapter XVIII of the federal social security act (medicare) and article forty-three of the insurance law plans, the information required to effectuate the provisions of this section, exclusive of adjustments for uncovered services.

12. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter for patient services rendered shall not exceed the rates of payment approved by the superintendent of financial services or approved or certified by the commissioner, whichever is applicable and required by this section, for payments by such article forty-three insurance law corporations or article forty-four organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article forty-three insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the schedule of charges established by such hospital for patient services in effect on May first, nineteen hundred seventy-eight, adjusted for the rate year nineteen hundred eighty-three in accordance with the provisions of subdivision thirteen of this section, and adjusted for the rate years thereafter in accordance with the provisions of subdivision six of this section.

(b) Any general hospital which has notified in writing an article forty-three corporation or a comprehensive health services plan prior to

June first, nineteen hundred seventy-eight of its intention to terminate its contract with such corporation or plan in accordance with the terms of such contract, except a general hospital subject to the provisions of paragraph (a) of this subdivision may not charge a subscriber or beneficiary of a contract entered into pursuant to the provisions of article forty-three of the insurance law, or a member of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, after the effective date of termination of such contract, amounts in excess of the schedule of charges established by such hospital for patient services in effect on May first, nineteen hundred seventy-eight, adjusted for the rate year nineteen hundred eighty-three in accordance with the provisions of subdivision thirteen of this section, and adjusted for the rate years thereafter in accordance with the provisions of subdivision six of this section.

(c) No general hospital shall refuse to provide patient services to such subscribers or beneficiaries solely on the grounds of such subscription or membership.

13. Charge control. For the period January first, nineteen hundred eighty-three, and until January first, nineteen hundred eighty-four:

(a) No general hospital shall establish charges for inpatient services in excess of those permitted by law immediately prior to the effective date of this section adjusted by the applicable trend factor.

(b) The commissioner shall establish an appeals board within the department to consider and recommend action in writing on an appeal by a general hospital of the inpatient charge limits established pursuant to this subdivision. The board and the commissioner may only consider, and appeals shall be limited to, changes in the base charge or the allowable limits because of the (i) establishment of an approved new hospital service, (ii) substantial changes in the volume of services provided, or (iii) substantial and adverse changes in the relationship between total accrued inpatient revenues and total inpatient costs due to such factors as significant increases in cost from labor settlements or increases in bad debts. Expenditures resulting from such changes must be essential to assure the continuance of quality medical care. In the event a determination on such appeal is not made by the commissioner within ninety days of receipt of a complete request as determined by the

commissioner, the hospital may increase its inpatient charges in conformance with such request. If the commissioner shall determine thereafter that all or a portion of such increase is not warranted hereunder, the hospital on notice of such determination shall promptly reduce its inpatient charges in conformance therewith. In no event shall the hospital bear any liability to any payor for such interim increase.

(c) In any proceeding under this subdivision the recognized collective bargaining agent shall be entitled to submit any relevant data. All data submitted hereunder shall be agency records under the freedom of information law. All proceedings and appeals hereunder shall be meetings of public bodies under the open meetings law.

(d) No provision of this subdivision or subdivision twelve of this section shall be construed to prohibit a general hospital from continuing the amount of inpatient charges in effect on May first, nineteen hundred seventy-eight.

14. Restitution authorization. In enforcing the provisions of subdivisions twelve and thirteen of this section, the commissioner may, in addition to the penalties and injunctions set forth in section twelve of this chapter, order that any general hospital provide restitution for any overpayments made by any party. Any hospital may request a formal hearing pursuant to the provisions of section twelve-a of this chapter in the event the hospital does not consent to any order of the commissioner hereunder. The commissioner may direct that such a hearing be held without any request by a hospital.

* NB Expired January 1, 1986

§ 2808-d. Nursing home quality improvement demonstration program. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner shall, within amounts appropriated and subject to the availability of federal financial participation, establish a demonstration program to improve the quality of care for nursing home residents through the increase or improvement of direct care staff at nursing homes. In furtherance of such demonstration program the commissioner shall adjust the Medicaid rates of payment to nursing homes, selected pursuant to a competitive process, provided, however,

that payments made pursuant to this section to public residential health care facilities shall be made as grants and shall not be deemed medical assistance payments. Requests for proposals for eligible projects shall be issued by the commissioner, provided however that the commissioner shall not issue any new requests for proposals after December thirty-first, two thousand four and all awards for subsequent annual periods shall be distributed on the same proportional basis as the most recent available distribution. After December thirty-first, two thousand four, awardees may use funds received for any of the purposes listed in subdivision two of this section, without restriction.

2. Such eligible projects may include:

- (a) an increase in direct care staff, either facility wide or targeted at a particular area of care or shift;
- (b) increased training and education of direct care staff, including allowing direct care staff to increase their level of licensure relevant to nursing home care;
- (c) efforts to decrease staff turn-over; and
- (d) other efforts related to the recruitment and retention of direct care staff that will effect the quality of care at such facility.

3. The commissioner shall consider, in selecting projects, the likelihood that such project will improve the care for the residents of the facility, the financial need of the nursing home and such other matters as the commissioner deems appropriate.

4. Grants and adjustments to Medicaid rates of payment made pursuant to this section shall not, in aggregate, exceed sixty-two million five hundred thousand dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two, and, on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand four, and shall not, in aggregate, exceed forty-six million eight hundred seventy-five thousand dollars for the period July first, two thousand five through December thirty-first, two thousand five and shall not, in aggregate, on an annualized basis, exceed seventy-eight million one hundred twenty-five thousand dollars for the period January first,

two thousand six through December thirty-first, two thousand six and sixty-two million five hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

5. Adjustments to Medicaid rates of payment made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

6. Notwithstanding any other provisions of this section or any other contrary provision of law, the commissioner may, from funds allocated pursuant to subparagraph (ii) or (iii) or (iv) of paragraph (u) of subdivision one of section twenty-eight hundred seven-v of this article, in calendar year two thousand five, make grants in an aggregate amount not to exceed twelve million five hundred thousand dollars, to residential health care facilities in support of projects or programs designed to improve specific areas of quality of care, as determined by the commissioner using established measures of such quality of care, and provided further the commissioner may, from funds allocated pursuant to paragraph (u) of subdivision one of section twenty-eight hundred seven-v of this article, for the period January first, two thousand six through June thirtieth two thousand seven, make grants in an aggregate amount not to exceed thirty-five million dollars on an annualized basis, to residential health care facilities that have an arbitrator's decision rendered before April first, two thousand six, requiring payments related to the recruitment and retention of direct care staff, including salary and benefits. Each eligible facility shall receive a payment amount proportional to the amount each such facility owes pursuant to the arbitrator's decision compared to such amounts owed by all eligible facilities.

*** § 2808-e. Residential health care for children with medical fragility in transition to young adults and young adults with medical fragility demonstration program.** 1. Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall, within amounts appropriated and subject to the availability of federal financial participation, establish a demonstration program for two eligible pediatric residential health care facilities, as defined in paragraph

(d) of subdivision two of this section, to construct a new facility or repurpose part of an existing facility to operate as a young adult residential health care facility for the purpose of improving the quality of care for young adults with medical fragility.

2. For purposes of this section:

(a) "children with medical fragility" shall mean children up to twenty-one years of age who have a chronic debilitating condition or conditions, are at risk of hospitalization, are technology-dependent for life or health sustaining functions, require complex medication regimens or medical interventions to maintain or to improve their health status, and/or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

(b) "young adults with medical fragility" shall mean individuals who meet the definition of children with medical fragility, but for the fact such individuals are aged between eighteen and thirty-five years old.

(c) "pediatric residential health care facility" shall mean a residential health care facility or discrete unit of a residential health care facility providing services to children under the age of twenty-one.

(d) "eligible pediatric residential health care facilities" shall mean pediatric health care facilities that meet the following eligibility criteria for the demonstration program set forth in subdivision one of this section: (i) has over one hundred and sixty licensed pediatric beds; or (ii) is currently licensed for pediatric beds pursuant to this article, is co-operated by a system of hospitals licensed pursuant to this article, and such hospitals qualify for funds pursuant to a vital access provider assurance program or a value based payment incentive program, as administered by the department in accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions.

3. Notwithstanding any law, rule, or regulation to the contrary, any child with medical fragility who has resided for at least thirty consecutive days in an eligible pediatric residential health care facility and who has reached the age of twenty-one while a resident, may

continue residing at such eligible pediatric residential health care facility and receiving such services from the facility, provided that such young adult with medical fragility remains eligible for nursing home care, and provided further that the eligible pediatric residential health care facility has prepared, applied for, and submitted to the commissioner, a proposal for a new residential health care facility for the provision of extensive nursing, medical, psychological and counseling support services to young adults with medical fragility in accordance with subdivision four of this section. A young adult with medical fragility may remain in such eligible pediatric residential health care facility until such time that the young adult with medical fragility attains the age of thirty-five years or the young adult residential health care facility is constructed and becomes operational, whichever is sooner.

4. Upon receipt of a certificate of need application from an eligible pediatric residential health care facility selected by the commissioner for the demonstration program authorized under this section, the commissioner is authorized to approve, with the written approval of the public health and health planning council pursuant to section twenty-eight hundred two of this article, the construction of a new residential health care facility to be constructed and operated on a parcel of land within the same county as that of eligible pediatric residential health care facility that is proposing such new facility and over which it will have site control, or the repurposing of a portion of a residential health care facility that is currently serving geriatric residents or those with similar needs for the provision of nursing, medical, psychological and counseling support services appropriate to the needs of nursing home-eligible young adults with medical fragility, referred to herein below as a young adult facility, provided that the established operator of such eligible pediatric residential health care facility proposing the young adult facility is in good standing and possesses at least thirty years' prior experience operating as a pediatric residential health care facility in the state or more than thirty years' experience serving medically fragile pediatric patients, and provided further that such facility qualifies for the demonstration program set forth in subdivision one of this section.

5. A young adult facility established pursuant to subdivision four of this section may admit, from the community-at-large or upon referral from an unrelated facility, young adults with medical fragility who prior to reaching age twenty-one were children with medical fragility, and who are eligible for nursing home care and in need of extensive nursing, medical, psychological and counseling support services, provided that the young adult facility, to promote continuity of care, undertakes to provide priority admission to young adults with medical fragility transitioning from the pediatric residential health care facility or unit operated by the entity that proposed the young adult facility and ensure sufficient capacity to admit such young adults as they approach or attain twenty-one years of age.

6. (a) For inpatient services provided to any young adults with medical fragility eligible for medical assistance pursuant to title eleven of article five of the social services law residing at any eligible pediatric residential health care facility as authorized in subdivision three of this section, the commissioner shall establish the operating component of rates of reimbursement appropriate for young adults with medical fragility residing at a pediatric residential health care facility, to apply to such young adults twenty-one years of age or older. Such methodology shall take into account the methodology used to establish the operating component of the rates pursuant to section twenty eight hundred eight of this article for pediatric residential health care facilities with an increase or decrease adjustment as appropriate to account for any discrete expenses associated with caring for young adults with medical fragility, including addressing their distinct needs as young adults for psychological and counseling support services.

(b) For inpatient services provided to any young adults with medical fragility eligible for medical assistance pursuant to title eleven of article five of the social services law at any young adult facility as authorized in subdivision four of this section, the commissioner shall establish the operating component of rates of reimbursement appropriate for young adults with medical fragility. Such methodology shall take into account the methodology used to establish the operating component

of the rates pursuant to section twenty eight hundred eight of this article for pediatric residential health care facilities with an increase or decrease adjustment as appropriate to account for any discrete expenses associated with caring for young adults with medical fragility, including addressing their distinct needs as young adults for psychological and counseling support services.

7. The commissioner shall have authority to waive any rule or regulation to effectuate the demonstration program authorized pursuant to subdivision one of this section.

* NB Repealed August 17, 2027

* NB There are 2 § 2808-e's

*** § 2808-e. Nursing home ratings.** 1. The commissioner shall provide that the most recent star rating of every nursing home facility in the state, assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (overall CMS rating), shall be prominently displayed on the home page of the department's website, or by an easily accessible link to such information.

2. Each nursing home facility shall post its overall CMS rating and ratings for health inspections, staffing and quality measures on the homepage of any website maintained by such facility and on any website or webpage relating to such facility maintained by an entity which owns or operates such facility. Each nursing home shall also conspicuously post its most recent overall CMS rating and ratings for health inspections, staffing and quality measures so that it is visible to the general public and to residents.

* NB There are 2 § 2808-e's

§ 2808-f. Advanced residential health care for aging adults medical fragility demonstration program. 1. Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall, within amounts appropriated and subject to the availability of federal financial participation, establish a demonstration program for eligible adult

residential health care facilities, as defined in paragraph (c) of subdivision two of this section, to construct a new facility or repurpose part of an existing facility to operate as an adult residential health care facility for the purpose of improving the quality of care for aging adults with medical fragility.

2. For purposes of this section:

(a) "Aging adults with medical fragility" shall mean adults from age thirty-five to end of life who have a chronic debilitating condition or conditions, are at risk of hospitalization, are technology-dependent for life or health sustaining functions, require complex medication regimens or medical interventions to maintain or to improve their health status, and/or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

(b) "Adult residential health care facility" shall mean a residential health care facility or discrete unit of a residential health care facility providing services to adults over the age of thirty-five.

(c) "Eligible adult residential health care applicant" shall mean adult health care facilities that meet the following eligibility criteria for the demonstration program set forth in subdivision one of this section: (i) is a nonprofit corporation that operates one hundred ten adult beds licensed under article sixteen of the mental hygiene law; or (ii) is licensed to provide diagnostic and treatment services pursuant to this article.

3. Upon receipt of a certificate of need application from an eligible adult residential health care applicant selected by the commissioner for the demonstration program authorized under this section, the commissioner is authorized to approve, with the written approval of the public health and health planning council pursuant to section twenty-eight hundred two of this article, the construction of a new residential health care facility to be constructed and operated on a parcel of land within the same county as that of an eligible adult residential health care applicant that is proposing such new facility and over which it will have site control, provided that such facility qualifies for the demonstration program set forth in subdivision one of

this section.

4. An aging adult facility established pursuant to subdivision three of this section may admit, from the community-at-large or upon referral from an unrelated facility, aging adults with medical fragility who, prior to reaching age thirty-five, were young adults with medical fragility, and who are eligible for nursing home care and in need of extensive nursing, medical, psychological and counseling support services, provided that the aging adult facility, to promote continuity of care, undertakes to provide priority admission to aging adults with medical fragility transitioning from the pediatric residential health care facility or unit operated by the entity that proposed the aging adult facility and ensure sufficient capacity to admit such adults as they attain thirty-five years of age.

5. For inpatient services provided to any aging adults with medical fragility eligible for medical assistance as authorized in subdivision three of this section, the commissioner shall establish the operating component of rates of reimbursement appropriate for aging adults with medical fragility residing at an adult residential health care facility, to apply to such adults thirty-five years of age or older. Such methodology shall take into account the methodology used to establish the operating component of the rates pursuant to section twenty-eight hundred eight of this article for adult residential health care facilities with an increase or decrease adjustment as appropriate to account for any discrete expenses associated with caring for aging adults with medical fragility, including addressing their distinct needs as aging adults for medical and psychological support services.

§ 2809. Residential health care facilities; powers to require security. 1. If a residential health care facility receives a rating in the lowest category which may be assigned pursuant to subdivision one of section twenty-eight hundred three of this chapter, the commissioner may require, as a condition of continuing to operate, that the facility obtain financial security to ensure that future obligations will be met, which security may be of a form that the commissioner deems appropriate,

and which shall be in an amount determined necessary by the commissioner after considering the rating of the facility; deficiencies in its overall condition and its operating practices; the size of the facility; the ease or difficulty of obtaining given types of security; and the financial burden of obtaining particular types of security; but in no case shall such amount exceed twenty-five thousand dollars.

2. If the commissioner obtains the agreement of any such facility to correct or eliminate any deficiency, by release or compromise of a penalty or for any other reason, he may require as a part of such agreement that the facility obtain security in an amount sufficient to ensure that the agreement be upheld, which security may take a form which the commissioner deems appropriate.

3. If for any reason the security required by the commissioner is depleted, either wholly or partially by civil penalties assessed by the commissioner or for any other cause, the commissioner may require, after considering those factors which were applicable to the original requirement of security, that the amount of security be wholly or partially replenished, or that the total amount of security be increased; but in no case shall such security exceed twenty-five thousand dollars at one time.

§ 2810. Residential health care facilities; receivership. 1. The owner or owners of any residential health care facility may at any time request the department to take over the operation of such facility by the appointment of a receiver. Upon receiving such a request, the department may, if it deems such action desirable, enter into an agreement with any such owners on the appointment of a receiver to take charge of the facility under whatever conditions as shall be found acceptable by both parties. Receivership commenced in accordance with the provisions of this subdivision shall terminate at such time as is agreed upon by the parties, or at such time as either party notifies the other in writing that he wishes to terminate such receivership.

2. a. As a means of protecting the health, safety and welfare of the

patients in a residential health care facility, whenever the commissioner revokes the operating certificate of such a facility he shall apply to the supreme court in the county where the facility is situated for an order directing the owner of the land and/or structure on or in which the facility is located to show cause why the commissioner, or his designee, should not be appointed receiver to take charge of the facility. In those cases where operating certificates have been revoked pursuant to paragraph (a) of subdivision five of section twenty-eight hundred six of this chapter the supreme court shall appoint a receiver who may be the commissioner or his designee. Such application shall contain proof by affidavit that the facility has had its operating certificate revoked. Such order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy thereof and the papers on which it is based on the owner or owners of the land and/or structure on or in which the facility is located. If any such owner cannot with due diligence be served personally within the county where the property is located and within the time fixed in such order, then service may be made on such person by posting a copy thereof in a conspicuous place within the facility in question, and by sending a copy thereof by registered mail, return receipt requested, to such owner at the last address registered by him with the department, or in the absence of such registration, to the address set forth in the last recorded deed with respect to such facility. Service shall be deemed complete on filing proof of service thereof in the office of the county clerk, or the clerk of the city of New York, as the case may be.

b. On the return of said order to show cause, determination shall have precedence over every other business of the court unless the court shall find that some other pending proceeding, having similar statutory precedence, shall have priority. The court may conduct a hearing at which all interested parties shall have the opportunity to present evidence pertaining to the application. If the court shall find that the facts warrant the granting thereof, then the commissioner, or any person designated by the commissioner, shall be appointed receiver to take charge of the facility, and the court shall determine a fair monthly rental for the facility, and for the furniture, fixtures and movable

equipment therein, taking into account all relevant factors, including the condition of such facility, and the condition of such furniture, fixtures and movable equipment, which amount shall, except in the case where the receiver is assuming an existing bona fide arm's length lease, not exceed the amount which would be reimbursable to the facility under the medical assistance program for real property costs and for the costs of furniture, fixtures and movable equipment if each patient in the facility were a recipient of medical assistance. Such rental shall be paid by the receiver to the owner or owners of the facility and to the owner or owners of the furniture, fixtures and movable equipment therein for each month that the receivership remains in effect.

c. Any receiver appointed pursuant to this subdivision shall have all of the powers and duties of a receiver appointed in an action to foreclose a mortgage on real property, together with such additional powers and duties as are herein granted and imposed. The receiver shall with all reasonable speed but, in any case, within eighteen months after the date on which the receivership was ordered provide for the orderly transfer of all patients in the facility to other facilities or make other provisions for their continued safety and health care. During the interim period when such patients must remain in the facility, the receiver may correct or eliminate those deficiencies in the facility that seriously endanger the life, health or safety of such patients provided that such correction or elimination of deficiencies does not include major alterations of the physical structure of the facility. He shall, during this period, operate the facility in such a manner as to guarantee safety and adequate health care for such patients. He shall have the power to let contracts therefor or incur expenses provided that where individual items of repairs, improvements or supplies exceed three thousand dollars, the receiver shall obtain price quotations from at least three reputable sources. The receiver shall not be required to file any bond. He shall collect incoming payments from all sources and apply them to the costs incurred in the performance of his functions as receiver. The receiver shall honor all existing leases, mortgages and chattel mortgages that had previously been undertaken as obligations of the owners or operators of the facility. No security interest in any real or personal property comprising the facility or contained within

the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the receiver. The receiver shall compensate the owner or owners of any goods held in inventory for those goods which he uses or causes to be used by reimbursing the costs of such goods, except that no such compensation shall be made for any such goods for which the owners or operators of the facility have already been reimbursed. Neither the receiver nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

d. The receiver shall be entitled to the same fees, commissions and necessary expenses as receivers in actions to foreclose mortgages. The receiver shall be liable only in his official capacity for injury to person and property by reason of conditions of the facility in a case where an owner would have been liable; he shall not have any liability in his personal capacity, except for gross negligence and intentional acts. The personnel and facilities of the department shall be available to the receiver for the purposes of carrying out his duties as receiver and the cost of such services shall be deemed a necessary expense of the receiver.

e. (i) The court shall terminate the receivership only under any of the following circumstances:

(a) eighteen months after the date on which it was ordered;

(b) when the department grants the facility a new operating certificate, whether the structure of the facility or the land on which it is located shall be under the same or different ownership; or

(c) at such time as all of the patients in the facility have been provided alternative modes of health care, either in another facility or otherwise.

(ii) At the time of termination, the receiver shall render a full and complete accounting to the court and shall make disposition of surplus money at the direction of the court.

f. (i) Any person who is served a copy of an order of the court appointing the receiver shall, upon being notified of the name and address of the receiver, make all payments for goods supplied by the

facility, or services rendered by the facility, to the receiver. A receipt shall be given for each such payment, and copies of all such receipts shall be kept on file by the receiver. The amount so received shall be deposited by the receiver in a special account which shall also be used for all disbursements made by the receiver.

(ii) Any person refusing or omitting to make such a payment after such service and notice may be sued therefor by the receiver. Such person shall not in such suit dispute the authority of the receiver to incur or order such expenses, or the right of the receiver to have such payments made to him. The receipt of the receiver for any sum paid to him shall, in all suits and proceedings and for every purpose, be as effectual in favor of any person holding the same as actual payment of the amount thereof to the owner or other person or persons who would, but for the provisions of this subdivision, have been entitled to receive the sum so paid. No patient shall be discharged, nor shall any contract or rights be forfeited or impaired, nor any forfeiture or liability be incurred, by reason of any omission to pay any owner, contractor or other person any sum so paid to the receiver.

g. Any other provision of this chapter notwithstanding, the department may, if it deems appropriate, grant to any facility operating or scheduled to operate under a receivership authorized by this subdivision an operating certificate the duration of which shall be limited to the duration of the receivership.

h. No provision contained herein shall be deemed to relieve the owner or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner or any other person prior to the appointment of any receiver hereunder, nor shall anything contained herein be construed to suspend during the receivership any obligation of the owner or any other person for the payment of taxes or other operating and maintenance expenses of the facility nor of the owner or any other person for the payment of mortgages or liens.

* 3. The commissioner is authorized to make non-interest bearing payments to receivers appointed pursuant to this section within the amounts made available therefor by the legislature. No such payment

shall be made unless the commissioner reasonably anticipates that repayment shall be made prior to or upon termination of the receivership. Any such payment to a receiver shall be made pursuant to a repayment agreement entered into by the receiver with the commissioner which shall specify a time within which full repayment must be made. Repayments by receivers shall be applied to reimburse any first instance appropriation made for the purposes of this subdivision.

* NB (Effective pending Federal Law)

§ 2811. Discounts and splitting fees with medical referral services; prohibited. No hospital or facility delivering health care shall grant or receive a discount to or from any medical referral service or in any manner split fees with a medical referral service.

§ 2812. Construction. Notwithstanding the provisions of any general, special or local law, or any city charter or administrative code to the contrary, no county, town, village or city shall enact and enforce regulations and standards for hospitals, except for hospitals maintained and operated by the health services administration of the city of New York or the New York city health and hospitals corporation.

§ 2813. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

*** § 2814. Health networks, global budgeting, and health care demonstrations.** 1. For the purposes of this section unless the context clearly requires otherwise:

(a) "Board" shall mean the temporary statewide health advisory board

established pursuant to section nine hundred fifty-seven of the executive law.

(b) "Proposal" shall mean a design or plan developed, as a result of funds received pursuant to this section, to operate a network, global budget, or regional health care demonstration.

2. (a) Notwithstanding any inconsistent provision of law, within amounts available therefor, the commissioner shall make grants pursuant to this section to (i) health care providers to facilitate development of health networks or health care demonstrations (ii) health care providers alone or in conjunction with third party payors to facilitate development of global budgets and (iii) an organization demonstrably representing the interests of the region or communities of the region which demonstrate the support of the respective health systems agency to facilitate development of health care demonstrations or global budgets. Such networks, demonstrations, or global budgets shall be designed to improve cost effectiveness of health care services, establish and improve provider coordinated planning and management mechanisms, and/or improve provider management of care or improve continuity of care. Health care providers eligible to receive funding under section twenty-nine hundred fifty-two of this chapter shall not be eligible for grants under this section for development of health networks.

(b) Grants made pursuant to this section shall provide planning funds which may include, but need not be limited to, funding to:

(i) assess the health care needs of the population and develop an operational plan to meet these needs;

(ii) plan for and carry out any organizational changes needed to integrate services; and

(iii) facilitate financing arrangements such as risk sharing and capitation.

3. In awarding grants under this section, the commissioner shall consult with the appropriate local health systems agency and shall consider the recommendations of the temporary statewide health advisory board on the grant proposals and to the extent practicable assure that there is a sufficiently representative geographic distribution of grantees including rural, urban, and suburban grantees. Grants made

pursuant to this section shall be used solely for the planning of health networks, global budgets or health care demonstrations. Prior to awarding grants, the commissioner shall first take into consideration other financial resources available to the applicant to conduct such planning.

4. In order to be eligible for a grant under this section, applicants shall prepare and submit to the commissioner, the temporary statewide health care advisory board, and the respective health systems agency an application which contains the following:

(a) identification of the principal investigator or applicant for the demonstration;

(b) a description of the nature and scope of the activities contemplated;

(c) a description of the geographic area and populations currently served by the entity;

(d) a description of the community or population to be served;

(e) a description of the anticipated benefits and advantages to providers and consumers of services;

(f) a description of the estimated expenses, including administrative expenses, which will be incurred in the development of the demonstration; and

(g) the time frame proposed for the development of the health network, global budgeting demonstration, or health care demonstration.

(h) the process that the eligible organization used in seeking public participation and local involvement in the development of the program plan; and

(i) the goals of the program, including information on how the program plan will maintain and promote access to and delivery of high quality, appropriate health or health related items and services for persons residing in the region covered by the program.

5. Any grant recipient seeking to implement a proposal developed pursuant to this section, except recipients of health networking grants, shall submit such proposal to the temporary statewide health advisory board, in such form and content determined by the board, which shall evaluate such proposal and consider whether the proposal is likely to:

- (a) aid in meeting the priority health needs and concerns in the region as identified in and supported by evidence in the proposal and consistent with recommendations of the regional health systems agency;
- (b) enhance the quality of care as evidenced by outcome indicators;
- (c) improve the cost-effectiveness of services by the entities involved;
- (d) improve the efficient utilization of the entities' resources and capital equipment;
- (e) enhance the provision of services that would otherwise not be available;
- (f) result in the elimination of unnecessary duplication of resources;
- (g) reduce costs to individuals being served by the network;
- (h) foster information sharing, communications and cooperation between health care providers; and
- (i) foster and improve the management and continuity of care.

6. In addition, the board shall require that the proposal contain assurances that there will be equitable provider involvement in the determination of any rates and rate setting methodology. The board shall also require a description of how the proposed initiative will be evaluated and assurance that the grantee will submit annual reports to the governor and legislature concerning the status and experiences of the initiative.

7. The temporary statewide health advisory board shall forward only proposals recommended for operation to the commissioner for authorization. In granting his authorization, the commissioner shall certify that the proposal will:

- (a) improve the cost effectiveness of health care services;
- (b) improve the quality of care delivered as evidenced by outcome indicators; and
- (c) improve access to appropriate health care services.

8. Upon request by an applicant or grantee the commissioner and the respective health system agency shall provide technical assistance.

9. The commissioner shall submit to the chairs of the senate finance

committee and the assembly ways and means committee and the chairs of the assembly and senate health committees, a copy of any proposal authorized by the commissioner pursuant to this section not more than thirty days after approval.

10. With the exception of health networks, global budgets or health care demonstrations that seek to implement alternative reimbursement methodologies in general hospital settings only and/or for ambulatory services associated with general hospital outpatient and diagnostic and treatment center settings regarding payment for the medical assistance program, as provided for in subdivisions ten and eleven of section twenty-eight hundred seven of this article, no health network, global budget or health care demonstration that seeks to implement alternative reimbursement methodologies shall be approved or implemented without approval pursuant to a chapter of the laws to be enacted by the legislature.

* NB Expired June 30, 1996

§ 2815. Health facility restructuring program. 1. Definitions. As used in this section, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context:

(a) "Agency" shall mean the New York state housing finance agency created by article three of the private housing finance law.

(b) "Authority" shall mean the dormitory authority of the state of New York created by title four of article eight of the public authorities law which has succeeded to the powers, functions and duties of the medical care facilities finance agency pursuant to chapter eighty-three of the laws of nineteen hundred ninety-five.

(c) "Participating borrower" shall mean a not-for-profit general hospital, a not-for-profit diagnostic center, a not-for-profit treatment center, a not-for-profit residential health care facility or any other not-for-profit entity in possession of a valid operating certificate issued pursuant to this article, each organized under the laws of this state, which has been approved for participation in this program by the commissioner.

(d) "Restructuring pool" shall mean the health facility restructuring pool authorized to be established by the authority pursuant to this section.

2. The authority shall establish the restructuring pool. Funds shall be transferred by the commissioner to the authority for deposit in the restructuring pool as authorized pursuant to paragraph (d) of subdivision one of section twenty-eight hundred seven-l and paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article or any other provision of law. Funds in the restructuring pool shall be held by the authority pursuant to this section as custodian, administered by the authority pursuant to an agreement with the commissioner and invested by the authority in accordance with the investment guidelines of the authority. All investment income shall be credited to, and any repayments of loans as hereinafter provided shall be deposited in, the restructuring pool, and spent therefrom only for the purposes set forth in this section.

3. The commissioner, the authority and the agency shall enter into an agreement, subject to the approval of the director of the budget, for the purpose of administering the funds in the restructuring pool in a manner that will benefit the public health by encouraging improvements in the health care delivery system in the state. A copy of such agreement, and any amendment thereto, shall be provided to the chair of the senate finance committee, the director of the division of budget, and the chair of the assembly ways and means committee. Such agreement shall include, but not be limited to, the following provisions:

(a) for the receipt, management and expenditure of funds held in the restructuring pool by the authority;

(b) for the development and implementation of business plans for participating borrowers, addressing the development of service delivery strategies, including strategies for the formation or strengthening of networks, affiliations or other business combinations, designed to provide long-term financial stability within and among participating borrowers;

(c) for the expenditure or loan of funds by the authority from the restructuring pool to reimburse the authority or the agency, where

appropriate, for the costs of engaging management, legal or accounting consultants to identify, develop and implement improved strategies for one or more participating borrowers for implementing the recommendations of such consultants, where appropriate, and for the payment of debt service on bonds, notes or other obligations issued or incurred by the authority or the agency to fund loans to one or more participating borrowers;

(d) for assurances that participating borrowers will address the recommendations of such consultants and furnish the commissioner, the authority, and where applicable, the agency, with such additional financial, management, legal and operational information as each may deem necessary to monitor the performance of a participating borrower; and

(e) for the agency to obtain funds from the restructuring pool to be used for the purposes set forth in this section.

3-a. Any participating borrower may apply for restructuring pool funds to the extent such funds are derived from deposits made pursuant to paragraph (d) of subdivision one of section twenty-eight hundred seven-1 of this article, provided, however, that, in reviewing such applications, the commissioner and the authority shall consider the extent to which the applicant hospital has alternative available sources of funds, including, but not limited to, funds available through affiliation agreements with other hospitals or entities.

4. To the extent funds are available from a participating borrower therefor, expenditures from the restructuring pool shall be repaid to the restructuring pool from repayments received by the authority, or the agency where applicable, from a participating borrower pursuant to the terms of any financing agreement, mortgage or loan document permitting the recovery from the participating borrower of such expenditures. The authority shall record and account for all such payments, which shall be deposited in the restructuring pool.

5. Loans from the restructuring pool shall be made pursuant to an agreement with the participating borrower specifying the terms thereof, including repayment terms. The authority shall record and account for

all such repayments, which shall be deposited in the restructuring pool. The authority shall notify the chair of the senate finance committee, the director of the division of budget, the chair of the assembly ways and means committee, the chair of the senate committee on health, and the chair of the assembly health committee, five days prior to the making of a loan from the restructuring pool. The authority shall also report quarterly to such chairpersons on the transactions in the pool, including but not limited to receipts or deposits to the pool, disbursements or loans made from the pool, investment income, and the balance on hand as of the end of the month for each such quarter.

5-a. Notwithstanding anything in this section to the contrary, the authority is authorized and directed to transfer from the restructuring pool to the department, upon written request of the director of the budget and within thirty days thereof, funds repaid by participating borrowers, and held by the authority relating to restructuring pool loans funded by amounts transferred to the restructuring pool by the department or remaining funds in the restructuring pool that were transferred by the department, not to exceed a total of eighty-three million five hundred thousand dollars, excepting therefrom amounts necessary to pay expenses of the authority as provided in the agreement described in subdivision three of this section. All participating borrowers shall be obligated in their loan agreement to repay no later than March thirty-first, two thousand twenty all funds borrowed from the eighty-three million five hundred thousand dollars transferred by the department pursuant to this section, to fund these restructuring pool loans. Further, in respect of these borrowed funds, all participating borrowers shall be required under the terms of their loan agreement to immediately upon receipt of quality improvement incentive payments or additional supplemental assistance initiate repayment of an amount equal to the quality improvement incentive payments or additional supplemental assistance not to exceed the amount of such borrowed funds, unless a waiver or extension of repayment has been approved by the director of the budget.

6. The commissioner is authorized, with the assistance and cooperation of the authority, to provide a program of technical assistance to

participating borrowers.

§ 2815-a. Community health care revolving capital fund. 1.

Definitions. As used in this section, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context:

a. "Administrator" shall mean a not for profit Community Development Financial Institution CDFI that is certified by the U.S. Treasury community development financial fund, has experience financing projects in the New York state healthcare sector and otherwise meets the requirements of this section.

b. "Dormitory authority" or "authority" shall mean the dormitory authority of the state of New York created by title four of article eight of the public authorities law which has succeeded to the powers, functions and duties of the medical care facilities finance agency pursuant to chapter eighty-three of the laws of nineteen hundred ninety-five.

c. "Participating borrower" shall mean a community-based health care provider, which for the purposes of this section, shall be defined as diagnostic and treatment center licensed or granted an operating certificate under article twenty-eight of this chapter, a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental health law; or an alcohol and substance abuse treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law, each organized under the laws of this state.

d. "Revolving capital fund" shall mean community health care revolving capital fund authorized to be established by the dormitory authority and administered pursuant to this section.

2. Revolving capital fund. The dormitory authority shall, within amounts appropriated, establish the community health care revolving

capital fund. Monies in the revolving capital fund shall be utilized for the purpose of making loans to qualifying participating borrowers to improve access to affordable capital financing to expand and improve capacity to provide health care in the State. Funds shall be transferred by the commissioner to the dormitory authority for deposit in the revolving capital fund in an amount as authorized by appropriation. Monies in the fund shall be: (a) held by the authority pursuant to this section as custodian pursuant to an agreement with the commissioner until transferred to the administrator pursuant to this section, and (b) invested by the authority in accordance with the investment guidelines of the authority during said custodial period. All investment income shall be credited to, and shall be deposited in, the revolving capital fund.

3. Administration agreement. The commissioner and the authority shall enter into an agreement, subject to the approval of the director of the budget, for the purpose of administering the funds in the revolving capital fund through an administrator. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the director of the division of budget, and the chair of the assembly ways and means committee. The agreement shall specify that the administrator shall administer the community health care revolving capital fund in a manner that will benefit the public health by encouraging improvements in the community health care delivery system in the state, in compliance with all applicable laws, rules, regulations and other requirements.

4. Agreement with the administrator. The dormitory authority shall, in consultation with the commissioner, enter into an agreement with the administrator. Such agreement shall provide for the administration of the revolving capital fund administrator, in accordance with the requirements of this section, the commissioner and dormitory authority and all applicable laws, rules, regulations and other requirements. Upon the effective date of the agreement, custody of, and responsibility for, the revolving capital fund shall be transferred from the dormitory authority to the administrator, subject to the requirements of the agreement. Such agreement shall include, but not be limited to, the

following provisions:

a. That the administrator shall be responsible for the receipt, management and expenditure of monies held in the revolving capital fund;

b. That the administrator shall maintain books and records pertaining to all monies received and disbursed pursuant to this section and the agreement;

c. That monies in such revolving capital fund shall be utilized for the purpose of making loans to qualifying participating borrowers, to provide participating borrowers with improved access to affordable capital to expand and improve preventive or primary care capacity;

d. That participating borrowers shall be chosen by the administrator through an application process approved by the authority and the commissioner;

e. That eligible uses of funds so loaned to participating borrowers shall include but not be limited to: (i) eligible costs as described in paragraph (f) of this subdivision, attributable to the proposed construction, reconstruction, renovation, rehabilitation, refurbishing, expansion, upgrading and equipping of a participating borrower's community-based health care facility; (ii) reserves for credit enhancement including loan guarantees; (iii) loan loss and debt service reserves and subordinated loans; and (iv) facility financing, including loans for predevelopment, acquisition and construction, permanent financing and bridge loans;

f. That eligible costs under this section shall include, but not be limited to, all hard construction costs and associated professional and other costs, furniture, fixtures and equipment, including health information technology, acquisition, predevelopment due diligence, initial operating expenses and working capital;

g. That the administrator administering the revolving capital fund shall report quarterly on the transactions in the revolving capital fund

in a form and manner specified by the authority in consultation with the commissioner, including but not limited to: receipts or deposits to the fund, disbursements, loans or credit enhancement made from the fund, investment income, and the balance on hand as of the end of the month for each such quarter;

h. That the administrator shall be required to invest monies on deposit in the fund in accordance with investment guidelines meeting the requirements of the department and dormitory authority, and all investment income shall be credited to, and any repayment of loans as hereinafter provided shall be deposited in, the revolving capital fund, and spent therefrom only for the purposes set forth in this section;

i. That only the reasonable expenses of the administrator, as determined by the commissioner and president of the authority, incurred in the establishment and administration of the revolving capital loan program (including the retention of professionals and consultants, if any) may be paid or reimbursed from the revolving capital fund;

j. That revolving capital fund monies shall be held in trust and used for the benefit of eligible community-based health care facility capital projects; and

k. Any other term or condition as determined by the authority, in consultation with the commissioner.

5. Loan documentation. Loans from the revolving capital fund shall be made pursuant to a written loan agreement between the administrator and the participating borrower, specifying the terms thereof including repayment terms. The loan agreement shall be in such form and content as shall be acceptable to the commissioner and dormitory authority, and may include such other any further written documentation and/or agreements as shall be required in the judgment of the commissioner and dormitory authority, including but not limited to all required filings under the Uniform Commercial Code.

*** § 2816. Statewide planning and research cooperative system. 1. (a)**

The statewide planning and research cooperative system in the department is continued, as provided in and subject to this section, within amounts appropriated for that purpose. The system shall be developed and operated by the commissioner in consultation with the council, as may be specified by regulation of the commissioner. Any component or components of the system may be operated under a different name or names, and may be structured as separate systems. In making regulations under this section, subsequent to April first, two thousand eleven, the commissioner shall consult with the superintendent of financial services or the head of any agency that succeeds the department of financial services, health care providers, third-party health care payers, and advocates representing patients; protect the confidentiality of patient-identifiable information; promote the accuracy and completeness of reporting; and minimize the burden on institutional and non-institutional health care providers and third-party health care payers.

(b) As used in this section, unless the context clearly requires otherwise:

(i) "Health care" means any services, supplies, equipment, or prescription drugs referred to in subdivision two of this section.

(ii) "Health care provider" includes, in addition to its common meanings, a clinical laboratory, a pharmacy, an entity that is an integrated organization of health care providers, and an accountable care organization of health care providers.

(iii) "System" means the statewide planning and research cooperative system under this section, and any separate system under this subdivision.

(iv) "Third-party health care payer" includes, but is not limited to, an insurer, organization or corporation licensed or certified pursuant to article thirty-two, forty-three or forty-seven of the insurance law, or article forty-four of the public health law; or an entity such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

(v) "Covered person" is a person covered under a third-party health care payer contract, agreement, or arrangement.

2. Notwithstanding any provision of law to the contrary, regulations governing the system shall include, but not be limited to, the following:

(a) Specification of patient, covered person, claims, and other data elements and format which shall be reported including data related to:

(i) inpatient hospitalization data from general hospitals;

(ii) ambulatory surgery data from hospital-based ambulatory surgery services and all other ambulatory surgery facilities licensed under this article;

(iii) emergency department data from general hospitals;

(iv) outpatient, clinical laboratory, and prescription data, including but not limited to data from or relating to services, supplies, equipment, and prescription drugs provided or ordered by general hospitals and diagnostic and treatment centers licensed under this article, pharmacies, clinical laboratories, and other health care providers;

(v) covered person and claims data; and

(vi) the data specified in this paragraph shall include the identification of patients transferred, admitted or treated subsequent to a medical, surgical or diagnostic procedure by a licensed health care professional or at a health care site or facility.

(b) Standards to assure the protection of patient privacy in data collected, published, released, used and accessed under this section, including compliance with applicable federal law.

(c) Standards for the publication, release, and use of and access to data reported in accordance with this section, including fees to be charged.

(d) Provisions requiring specified health care providers and third-party health care payers to report data to the system, with specifications of the data, circumstances, format, time and method of reporting.

(e) Provisions to acquire data relating to health care provided (i) to patients for whom there is no third-party health care payer and (ii) under arrangements that do not involve fee-for-service payment.

(f) Phased-in implementation of the system.

3. The commissioner may provide that the system may participate in or cooperate with a similar system operated by, or receive information from or provide information to, a regional or national entity or another jurisdiction, including making appropriate agreements and applying for approvals, provided that the protections for health care providers, patients, and third-party health care payers in this section are preserved and comparable provisions are included in the other system.

4. The commissioner may provide for access to data in the system by a health care provider relating to a patient being treated by the health care provider, subject to this section and applicable state and federal law.

5. In operating the system, the commissioner shall consider national standards, including but not limited to those approved by the National Uniform Billing Committee (NUBC) or required under national electronic data interchange (EDI) standards for health care transactions. The commissioner shall also consider the use of the Statewide Health Information Network for New York in relation to the system.

6. Notwithstanding any inconsistent provision of law to the contrary, including but not limited to section one hundred two of the executive law, such rules and regulations may describe data elements by reference to information reasonably available to regulated parties, as such material may be amended in the future, even though such material cannot be precisely identified to the extent that it is amended in the future; provided, however, that the commissioner shall precisely identify and publish such data elements.

7. The commissioner may contract with one or more entities to operate any part of the system subject to this section.

8. The commissioner may accept grants and enter into contracts as may be necessary to provide funding for the system.

9. The commissioner shall publish an annual report relating to health care utilization, cost, quality, and safety, including data on health

disparities.

* NB Effective until March 31, 2029

* § 2816. Statewide planning and research cooperative system. 1. The statewide planning and research cooperative system in the department is continued, as provided in this section. The statewide planning and research cooperative system shall be developed and operated by the commissioner in consultation with the council, and shall be comprised of such data elements as may be specified by regulation.

2. Regulations governing the statewide planning and research cooperative system shall include, but not be limited to, the following:

(a) Specification of patient and other data elements and format to be reported including data related to:

(i) inpatient hospitalization data from general hospitals;

(ii) ambulatory surgery data from hospital-based ambulatory surgery services and all other ambulatory surgery facilities licensed under this article;

(iii) emergency department data from general hospitals;

(iv) outpatient clinic data from general hospitals and diagnostic and treatment centers licensed under this article, provided, however, that notwithstanding subdivision one of this section the commissioner, in consultation with the health care industry, is authorized to promulgate or adopt any rules or regulations necessary to implement the collection of data pursuant to this subparagraph; and

(v) the data specified in this paragraph shall include the identification of patients transferred, admitted or treated subsequent to a medical, surgical or diagnostic procedure by a licensed health care professional at a site or facility other than those specified in subparagraph (i), (ii), (iii) or (iv) of this paragraph.

(b) Standards to assure the protection of patient privacy in data collected and released under this section.

(c) Standards for the publication and release of data reported in accordance with this section.

* NB Effective March 31, 2029

§ 2816-a. Cardiac services information. 1. Definitions. For the

purposes of this section, the following terms shall have the following meanings:

(a) "Cardiac services information" shall mean the demographic, clinical, procedural and outcome information collected from hospitals and maintained by the department regarding patients who have been diagnosed or treated for cardiac disease or conditions.

(b) "Cardiac data set" shall mean a subset of cardiac services information consisting of data elements relevant to a research project.

2. Notwithstanding articles six and six-A of the public officers law, the commissioner may collect and maintain cardiac services information and prepare and release cardiac data sets for use in research projects as set forth in this subdivision. Any cardiac data set released shall contain the minimum amount of personally identifiable and demographic information which the commissioner determines is necessary to conduct the research project provided, however, that no cardiac data set shall be released that contains patient names, social security numbers, or other data elements that directly identify any patient.

3. The commissioner may release cardiac data sets for research projects based on the following factors:

(a) the research project's potential contribution to improving the quality of care and outcomes experienced by patients receiving cardiac services, the appropriateness of cardiac services, access to cardiac services, and/or the cost effectiveness of cardiac services;

(b) the technical feasibility of preparing the cardiac data set requested;

(c) the scientific merit of the research project;

(d) the experience and qualifications of the researchers;

(e) the research project's feasibility;

(f) the applicant's capacity and agreement to protect the confidentiality of the data;

(g) the research project's compliance with applicable state and federal laws, policies and regulations governing the protection of human subjects; and

(h) such other criteria as the commissioner develops in consultation with experts in cardiac services.

4. Any researcher authorized by the commissioner to access a cardiac data set shall:

- (a) maintain the security and confidentiality of the information;
- (b) not disclose the cardiac data set, or any portion thereof, unless specifically permitted to do so by the commissioner;
- (c) restrict the use of the data to the specific research project approved by the commissioner;
- (d) destroy, and document the destruction of, the data within a time period specified by the commissioner; and
- (e) execute and comply with a cardiac services data use agreement, which includes but is not limited to provisions restricting the use and disclosure of the data.

5. The commissioner shall charge a fee for each cardiac data set released. Such fee shall be payable to the department, prior to the release of any cardiac data set, for deposit into the general fund.

6. The commissioner may promulgate and enforce such rules and regulations as he or she deems necessary to effectuate the purposes of this section.

§ 2817. Community health centers capital program. 1. Definitions. As used in this section, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(a) "Community health center" means a not-for-profit corporation that is licensed under this article as a diagnostic and treatment center, which license is valid and in full force and effect, and that provides a comprehensive range of primary health care services in one or more freestanding sites, or a not-for-profit corporation that has applied for licensure under this article as a diagnostic and treatment center and that intends to provide a comprehensive range of primary health care services in one or more freestanding sites.

(b) "Program" means the community health centers program authorized by this section.

(c) "Program funds" means state funds available for the purposes of

this section.

(d) "Matching funds" means any funds other than state funds (whether derived from non-governmental or federal or local governmental sources), which are available for the purposes of this section.

(e) "Community health center project" or "project" means the construction, reconstruction, renovation, rehabilitation, refurbishing, expansion, upgrading, or equipping of a community health center under this section.

2. Agreements. The commissioner is authorized to make funds available for community health center projects. The commissioner shall contract with one or more not-for-profit administrators, each of which shall be a not-for-profit corporation having demonstrated interest, expertise and experience in the development and financing of primary care and preventive services in low income communities. The not-for-profit administrator shall award program funds and available matching funds to, or for the benefit of, community health centers which apply for such funds in accordance with this section. The commissioner and the not-for-profit administrator shall enter into an agreement for the purpose of administering the program and matching funds. Such agreement shall provide, without limitation, for the following:

(a) the receipt, management and expenditure of program funds and matching funds;

(b) the solicitation of capital proposals to be submitted by or on behalf of community health centers;

(c) the solicitation of matching funds;

(d) the process by which the capital proposals are reviewed, evaluated and funded; and

(e) the reasonable expenses of the not-for-profit administrator incurred in the establishment and administration of this program, including retention of professionals and consultants.

3. Matching funds. (a) To leverage the benefit of program funds available pursuant to this section for community health center projects, each allocation of program funds awarded to, or for the benefit of, a community health center shall be matched by an equal or greater amount of matching funds and shall be conditioned on the availability of such

matching funds for the community health center project.

(b) Matching funds shall be deemed available for the purposes of this section when the funds are deposited with the not-for-profit administrator, or are irrevocably committed for the community health center project pursuant to a valid, binding and enforceable contract, enforceable by the not-for-profit administrator for the benefit of the community health center project.

(c) Matching funds may be obtained by the not-for-profit administrator or may be otherwise provided for a particular community health center project. In each such circumstance, or combination thereof, the requirements of paragraph (b) of this subdivision shall apply.

4. Community health center projects. (a) An application to the not-for-profit administrator may be submitted by or on behalf of a community health center which meets the criteria for receiving funds set forth in this section.

(b) The application shall specify in detail acceptable to the not-for-profit administrator the proposed construction, reconstruction, renovation, rehabilitation, refurbishing, expansion, upgrading and equipping of a community health center.

(c) The application shall identify available sources of funds for the community health center project, including matching funds, if any. It shall also identify any expenses already incurred in connection with the community health center project, and whether any reimbursement therefor is sought in connection with the application.

(d) To receive an award of funds for the proposed community health center project, the applicant, and if the applicant is not a community health center, the community health center and the applicant, shall enter into an agreement with the not-for-profit administrator governing the disbursement of funds, construction of the proposed project, and any requirements of the program under the agreement between the commissioner and the not-for-profit administrator or otherwise required by law. The agreement may include provisions for the repayment of all or a portion of funds.

5. Funding criteria. A community health center project may be funded under this section provided the community health center meets the

criteria established in either of the following paragraphs:

(a) The community health center is a federally-qualified health center as defined in 42 U.S.C. section 1395x (aa); or

(b) The community health center (i) has applied to the United States Department of Health and Human Services for designation as a federally-qualified health center, (ii) is eligible for such designation, and (iii) is located in, serves or intends to serve a designated medically-underserved community as defined in 42 U.S.C. section 295p, a health professional shortage area as defined in 42 U.S.C. section 254e or a medically-underserved population as defined in 42 U.S.C. section 254b. A community health center that received funding pursuant to this paragraph, and does not secure designation as a federally-qualified health center within two years of its receipt of funds shall repay such funds as directed by the not-for-profit administrator.

6. Administration of funds. (a) Program funds shall be received and held by the not-for-profit administrator under this section and the agreement with the commissioner. Program funds shall be held in trust and used for the benefit of the community health center projects. All investment income shall be credited to, and any repayments of program funds shall be deposited in, the trust accounts established by the not-for-profit administrator for such purpose, and spent only for the purposes set forth in this section.

(b) Notwithstanding the foregoing, the not-for-profit administrator may withdraw from the funds held by it under this section, subject to the agreement with the commissioner, amounts sufficient to pay or reimburse its expenses as provided in paragraph (e) of subdivision two of this section.

(c) The not-for-profit administrator shall maintain books and records pertaining to all moneys received and disbursed pursuant to this section. The agreement between the commissioner and the not-for-profit administrator shall provide for the distribution of funds upon the termination thereof. All remaining program funds, including earnings and repayments, if any, not subject to binding agreement for the expenditure thereof, shall be paid at the direction of the commissioner to the state comptroller to the credit of the general fund. Upon termination of the

agreement, matching funds held by the not-for-profit administrator not subject to binding agreement for the expenditure thereof, shall be applied consistent with the terms of the receipt of such matching funds, or returned to the donor.

§ 2818. Health care efficiency and affordability law of New Yorkers (HEAL NY) capital grant program. 1. The commissioner and the director of the dormitory authority of the state of New York shall enter into an agreement, subject to the approval of the director of the budget, for the purpose of administering the funds available to the health care efficiency and affordability law for New Yorkers (HEAL NY) capital grant program as authorized under section sixteen hundred eighty-j of the public authorities law, in a manner that will encourage improvements in the operation and efficiency of the health care delivery system within the state. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the director of the division of budget and the chair of the assembly ways and means committee.

Such agreement shall include criteria, to be developed by the commissioner and the director of the authority, to be considered in their evaluation of applications and determination of awards, including, but not limited to:

(a) determination of eligible applicants, provided that such eligible applicants shall include entities representative of any part of the health care delivery system;

(b) consideration of statewide geographic distribution of funds;

(c) minimum and maximum amounts of funding to be awarded under the program;

(d) the relationship between the project proposed by an applicant and identified community need; and

(e) the extent to which the applicant has access to alternative financing.

Such agreement shall be provided to the chair of the senate finance committee, the director of the division of budget and the chair of the

assembly ways and means committee no later than thirty days prior to the scheduled approval of the first bond issuance for the program by the public authorities control board. The authority shall also report quarterly to such chairpersons on the awards made through the program, including the name of the applicant, a description of the project and the amount of the award.

The commissioner and the director of the authority shall award grants to eligible applicants after due public notice of the availability of funds and through a process which ensures to the maximum extent practicable and where appropriate, competition among such applicants, consistent with the following requirements: the commissioner and the director of the authority shall publish the priorities and goals that are to be achieved through grant funding, and regularly provide public notice of the availability of funding. These priorities and goals shall be consistent with objectives and determinations of the Commission on Health Care facilities in the Twenty-First Century established pursuant to a chapter of the laws of two thousand five, provided, however, that nothing shall prohibit the commissioner and the director for the authority from awarding grants prior to a final report by the commission. For each project that will be recommended for approval, the commissioner and the director of the authority shall report to the chair of the senate finance committee, the director of the division of budget and the chair of the assembly ways and means committee how the project meets the priorities, goals and criteria established pursuant to this section.

Contracts awarded to eligible applicants shall require that work performed thereunder shall be deemed "public work" and subject to and preformed in accordance with articles eight, nine and ten of the labor law and the contractors performing such work shall also be deemed a state agency for the purpose of article fifteen-A of the executive law and subject to the provisions of such article.

2. Notwithstanding the provisions of subdivision one of this section, the commissioner and the director of the dormitory authority may award, in an amount not to exceed twenty-five percent of the health care system

improvement capital grant program allocation in any given fiscal year, grants to eligible applicants without the process set forth in subdivision one of this section. With respect to the process for the awarding of such funds without the process set forth in subdivision one of this section, the commissioner and the director of the dormitory authority shall determine eligible awardees based solely on an applicant's ability to meet the following criteria:

(i) Have a loss from operations for each of the three consecutive preceding years as evidenced by audited financial statements; and

(ii) Have a negative fund balance or negative equity position in each of the three preceding years as evidenced by audited financial statements; and

(iii) Have a current ratio of less than 1:1 for each of three consecutive preceding years; or

(iv) Be deemed to the satisfaction of the commissioner to be a provider that fulfills an unmet health care need for the community as determined by the department through consideration of the volume of Medicaid and medically indigent patients served; the service volume and mix, including but not limited to maternity, pediatrics, trauma, behavioral and neurobehavioral, ventilator, and emergency room volume; and, the significance of the institution in ensuring health care services access as measured by market share within the region.

(c) Prior to an award being granted to an eligible applicant without a competitive bid or request for proposal process, the commissioner and the director of the dormitory authority shall notify the chair of the senate finance committee, the chair of the assembly ways and means committee and the director of the division of budget of the intent to grant such an award. Such notice shall include information regarding how the eligible applicant meets criteria established pursuant to this section.

3. Notwithstanding subdivisions one and two of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other inconsistent provision of law, of the funds available for expenditure pursuant to this section, thirty million dollars may be allocated and distributed by the commissioner without a competitive bid or request for proposal process for grants to residential health care

facilities for the purpose of restructuring such facilities to achieve a reduction in certified inpatient bed capacity. Consideration relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (a) the existing and projected need for inpatient nursing home beds and community based long-term care services in the area in which a facility applying for such funds is located; (b) the quality of the care being provided by the facility; (c) the ability of the facility to access, in a timely manner, alternative sources of funding, including other sources of government funding; and (d) whether additional funding would permit the facility to achieve greater stability and efficiency in the delivery of needed health care services.

4. Notwithstanding the provisions of subdivision one of this section, the commissioner and the director of the dormitory authority may award, in an amount not to exceed twenty-five million dollars of the health care system improvement capital grant program allocated in any given fiscal year, grants to eligible applicants without the process set forth in subdivision one of this section to provide necessary restructuring support to hospitals for transition to a new reimbursement methodology.

(a) With respect to the process for the awarding of such funds without the process set forth in subdivision one of this section, the commissioner and director of the dormitory authority shall determine eligible awardees based solely on an applicant's ability to meet the following criteria:

(i) have a loss of operations for each of the three consecutive preceding years as evidence by audited financial statements; and

(ii) have a negative fund balance or negative equity position in each of the three preceding years as evidence by audited financial statements; and

(iii) have a current ratio of less than 1:1 for each of three consecutive preceding days; or

(iv) be deemed to the satisfaction of the commissioner to be a provider that fulfills an unmet health care need for the community as determined by the department through consideration of the volume of Medicaid and medically indigent patients served; the service volume and mix, including but not limited to maternity, pediatrics, trauma,

behavior and neurobehavioral, ventilator, and emergency room volume; and, the significance of the institution in ensuring health care services access as measured by market share within the region; or

(v) be deemed to the satisfaction of the commissioner to have incurred operating losses resulting from the implementation of reimbursement rate reforms and other reductions enacted by a chapter of the laws of two thousand nine, to provide for the continued financial viability of the applicant.

(b) Prior to an award being granted to an eligible applicant without a competitive bid or request for proposal process, the commissioner and the director of the dormitory authority shall notify the chair of the senate finance committee, the chair of the assembly ways and means committee and the director of the budget of the intent to grant such an award. Such notice shall include information regarding how the eligible applicant meets criteria established pursuant to this section.

5. (a) Notwithstanding subdivision one, two or three of this section, the commissioner, with the approval of the director of the budget, may expend funds for the purpose of providing cost effective increased access to the capital markets, including but not limited to through the use of mortgage insurance, credit enhancement, letters of credit, bond insurance or other arrangements, for capital projects that are determined to meet one or more of the following objectives for hospitals licensed under this article:

(i) securing financing for facilities in a manner that will improve the operation and efficiency of the health care delivery system within the state;

(ii) securing financing for facilities in a manner consistent with the objectives and determinations of the Commission on Health Care Facilities in the Twenty-First Century, established pursuant to chapter sixty-three of the laws of two thousand five;

(iii) securing financing for facilities in a manner that will help rightsize the state's acute care infrastructure, including reducing inpatient capacity, downsizing, restructuring, and closing facilities;

(iv) securing financing for facilities in a manner that advances the reform of the long-term care system, including through rightsizing and providing community-based services;

(v) securing financing for facilities in a manner that improves the primary and ambulatory care system including programs undertaken in collaboration with a local development corporation incorporated pursuant to sections four hundred one and one thousand four hundred eleven of the not-for-profit corporation law to foster the development and expansion of high quality, cost effective primary health care services and related ambulatory care and ancillary services benefiting medically underserved communities, principally in the state, to increase access of community residents to such services, to improve the health status of such residents and to lessen the burdens of government and act in the public interest; and

(vi) such other objectives as the commissioner deems appropriate to effectuate the intent of this subdivision.

(b) The commissioner may transfer funds to other state agencies or public authorities, with the approval of the director of budget, to effectuate the purposes of this subdivision.

6. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, subject to available appropriations, funds available for expenditure pursuant to this section may be distributed by the commissioner without a competitive bid or request for proposal process for grants to general hospitals and residential health care facilities for the purpose of facilitating closures, mergers and restructuring of such facilities in order to strengthen and protect continued access to essential health care resources. Provided however, that to the extent practicable, the commissioner shall award such grants equitably among health planning regions of the state. Prior to an award being granted to an eligible applicant without a competitive bid or request for proposal process, the commissioner shall notify the chair of the senate finance committee, the chair of the assembly ways and means committee and the director of the division of budget of the intent to grant such an award. Such notice shall include information regarding how the eligible applicant meets criteria established pursuant to this section.

7. Notwithstanding subdivisions one and two of this section, sections

one hundred twelve and one hundred sixty-three of the state finance law, or any other inconsistent provision of law, of the funds available for expenditure pursuant to this section, the commissioner may allocate and distribute, without a competitive bid or request for proposal process, grants to accountable care organizations under article twenty-nine-E of this chapter for the purpose of promoting their formation and improving their operation. Consideration relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the need for and capacity of the accountable care organization to accomplish the purposes of article twenty-nine-E of this chapter in the area to be served.

8. On or before December first, two thousand fourteen, the department shall issue a report to the governor, the temporary president of the senate and the speaker of the assembly regarding grants made pursuant to this section to support health information technology.

§ 2819. Hospital acquired infection reporting. 1. For the purposes of this section, "hospital acquired infection" shall mean any localized or systemic patient condition that:

(a) resulted from the presence of an infectious agent or agents, or its toxin or toxins as determined by clinical examination or by laboratory testing; and

(b) was not found to be present or incubating at the time of admission unless the infection was related to a previous admission.

2. (a) Each general hospital shall maintain a program capable of identifying and tracking hospital acquired infections for the purpose of public reporting under this section and quality improvement.

(b) Such programs shall have the capacity to identify the following elements: the specific infectious agents or toxins and site of each infection; the clinical department or unit within the facility where the patient first became infected; and the patient's diagnoses and any relevant specific surgical, medical or diagnostic procedure performed during the current admission.

(c) The department shall establish guidelines, definitions, criteria,

standards and coding for hospital identification, tracking and reporting of hospital acquired infections which shall be consistent with the recommendations of recognized centers of expertise in the identification and prevention of hospital acquired infections including, but not limited to the National Health Care Safety Network of the Centers for Disease Control and Prevention or its successor. The department shall solicit and consider public comment prior to such establishment.

(d) Hospitals shall be initially required to identify, track and report hospital acquired infections that occur in critical care units to include surgical wound infections and central line related bloodstream infections.

(e) For hospital acquired infections for which the department requires tracking and reporting as permitted in this section, hospitals shall be required to report a suspected or confirmed hospital-acquired infection associated with another hospital to the originating hospital. Documentation of reporting should be maintained for a minimum of six years.

(f) Subsequent to the initial requirements identified in paragraph (d) of this subdivision the department may, from time to time, require the tracking and reporting of other types of hospital acquired infections (for example, ventilator - associated pneumonias) that occur in hospitals in consultation with technical advisors who are regionally or nationally-recognized experts in the prevention, identification and control of hospital acquired infection and the public reporting of performance data.

3. Each hospital shall regularly report to the department the hospital infection data it has collected. The department shall establish data collection and analytical methodologies that meet accepted standards for validity and reliability. The frequency of reporting shall be monthly, and reports shall be submitted not more than sixty days after the close of the reporting period.

4. The commissioner shall establish a state-wide database of all reported hospital acquired infection information for the purpose of supporting quality improvement and infection control activities in hospitals. The database shall be organized so that consumers, hospitals,

healthcare professionals, purchasers and payers may compare individual hospital experience with that of other individual hospitals as well as regional and state-wide averages and, where available, national data.

5. (a) Subject to paragraph (c) of this subdivision, on or before September first of each year the commissioner shall submit a report to the governor and the legislature, which shall simultaneously be published in its entirety on the department's web site, that includes, but is not limited to, hospital acquired infection rates adjusted for the potential differences in risk factors for each reporting hospital, an analysis of trends in the prevention and control of hospital acquired infection rates in hospitals across the state, regional and, if available, national comparisons for the purpose of comparing individual hospital performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs.

(b) The commissioner shall consult with technical advisors who have regionally or nationally acknowledged expertise in the prevention and control of hospital acquired infection and infectious disease in order to develop the adjustment for potential differences in risk factors to be used for public reporting.

(c)(i) No later than July first, two thousand six, the department shall establish a hospital acquired infection reporting system capable of receiving electronically transmitted reports from hospitals. Hospitals shall begin to submit such reports as directed by the commissioner but in no case later than January first, two thousand seven.

(ii) The first year of data submission under this section shall be considered the "pilot phase" of the statewide hospital acquired infection reporting system. The purpose of the pilot phase is to ensure, by various means, including any audit process referred to in subdivision seven of this section, the completeness and accuracy of hospital acquired infection reporting by hospitals. For data reported during the pilot phase, hospital identifiers shall be encrypted by the department in any and all public databases and reports. The department shall provide each hospital with an encryption key for that hospital only to permit access to its own performance data for internal quality

improvement purposes.

(iii) No later than one hundred eighty days after the conclusion of the pilot phase, the department shall issue a report to hospitals assessing the overall accuracy of the data submitted in the pilot phase and provide guidance for improving the accuracy of hospital acquired infection reporting. The department shall issue a report to the governor and the legislature assessing the overall completeness and accuracy of the data submitted by hospitals during the pilot phase and make recommendations for the improvement or modification of hospital acquired infection data reporting based on the pilot phase as well as share lessons learned in prevention of hospital acquired infections. No hospital identifiable data shall be included in the pilot phase report, but aggregate or otherwise de-identified data may be included.

(iv) After the pilot phase is completed, all data submitted under this section and compiled in the statewide hospital acquired infection database established herein and all public reports derived therefrom shall include hospital identifiers.

6. Subject to subdivision five of this section, a summary table, in a format designed to be easily understood by lay consumers, that includes individual facility hospital acquired infection rates adjusted for potential differences in risk factors and comparisons with regional and/or state averages shall be developed and posted on the department's web site. The commissioner shall consult with consumer and patient advocates and representatives of reporting facilities for the purpose of ensuring that such summary table report format is easily understandable by the public, and clearly and accurately portrays comparative hospital performance in the prevention and control of hospital acquired infections.

7. To assure the accuracy of the self-reported hospital acquired infection data and to assure that public reporting fairly reflects what actually is occurring in each hospital, the department shall develop and implement an audit process.

8. For the purpose of ensuring that hospitals have the resources needed for ongoing staff education and training in hospital acquired

infection prevention and control, the department may make such grants to hospitals within amounts appropriated therefor.

9. Individual patient identifying information reported to the department under this section shall be subject to paragraph (j) of subdivision one of section two hundred six of this chapter. Regulations under this section shall include standards to assure the protection of patient privacy in data collected and released under this section and standards for the publication and release of data reported under this section.

*** § 2820. Home based primary care for the elderly demonstration project.** 1. Notwithstanding any law to the contrary there is hereby created a demonstration program within the department to determine the effectiveness of providing home based primary care services to elderly patients as part of an integrated program of long term care services. As part of the demonstration program a selected provider shall be authorized to provide physician, nurse-practitioner, physician assistant and nursing services in the home of patients age sixty-five or older and to other patients eligible for benefits pursuant to title XVIII of the federal social security act.

2. The department may approve up to three providers as part of the demonstration program.

3. In order to be an eligible provider an applicant must be licensed to provide residential health care services. In addition such applicant must also provide the following services: on-site rehabilitative services, continuing care retirement community licensed pursuant to article forty-six of this chapter or other residential services for the elderly or disabled licensed by the state and adult day services as authorized by the department.

4. Any provider selected to participate in the demonstration program shall annually report to the department on the number of patients served, the type of services provided, the cost of such services, the

sources of payment for such services, the number of patients served who no longer remain in their homes and such other information as required by the department to determine the effectiveness of the provision of home based physician and nurse-practitioner services on the health care of patients.

* NB Repealed January 1, 2031

§ 2821. State electronic health records (EHR) loan program. 1. Definitions. As used in this section, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context:

(a) "Authority" shall mean the dormitory authority of the state of New York created by title four of article eight of the public authorities law which has succeeded to the powers, functions and duties of the medical care facilities finance agency pursuant to chapter eighty-three of the laws of nineteen hundred ninety-five.

(b) "Eligible health care provider" shall mean any health care provider organized under the laws of this state eligible to receive federal funds, which has been approved for participation in this program by the commissioner.

(c) "EHR loan fund" shall mean the certified electronic health records technology loan fund authorized to be established by the authority pursuant to this section.

2. The authority shall establish the EHR loan fund. Funds shall be transferred or appropriated to the authority for deposit in the EHR loan fund as authorized pursuant to any provision of law. Funds in the EHR loan fund shall be held by the authority pursuant to this section as custodian, administered by the authority pursuant to an agreement with the commissioner and invested by the authority in accordance with the investment guidelines of the authority. All investment income shall be credited to, and any repayments of loans as hereinafter provided shall be deposited in, the EHR loan fund, and spent therefrom only for the purposes set forth in this section.

3. The commissioner and the authority shall enter into an agreement,

subject to the approval of the director of the division of the budget, for the purpose of administering the moneys in the EHR loan fund in a manner that will benefit the public health by encouraging improvements in the health care delivery system through the use of information technology in the state. Such agreement shall include, but not be limited to, the following provisions:

(a) for the receipt, management and expenditure of funds held in the EHR loan fund by the authority;

(b) for the development of program components, including but not limited to provider eligibility and terms and conditions of loans, and for the development and implementation of strategic plans for eligible health care providers, addressing the development of meaningful electronic health record improvements, including strategies for facilitating the purchase of certified electronic health records technology, enhancing the utilization of certified electronic health records technology, training personnel in the use of such technology and supporting the secure exchange of electronic health information to and from electronic health records; and

(c) other requirements set forth by the Secretary of the United States Department of Health and Human Services with respect to the state EHR loan fund for the expenditure by the authority from the EHR loan fund to reimburse the authority and the department for the cost of administering the loan fund.

4. Any eligible health care provider may apply for EHR loan funds to the extent such funds are derived from deposits made pursuant to law by the state. The commissioner and the authority shall consider the extent to which an eligible health care provider can provide matching funds that may be required by law.

5. To the extent funds are available from an eligible health care provider, expenditures from the EHR loan fund shall be repaid to the EHR loan fund from repayments received by the authority, from an eligible health care provider pursuant to the terms of any financing agreement, mortgage or loan document permitting the recovery from the eligible health care provider of such expenditures. The authority shall record the account for all such payments, which shall be deposited in the EHR

loan fund account.

6. Loans from the EHR loan fund shall be made pursuant to an agreement with the eligible health care provider specifying the terms thereof, including repayment terms. The authority shall record and account for all such repayments, which shall be deposited in the EHR loan fund. The authority shall report annually to the director of the division of budget, the chair of the senate finance committee and the chair of the assembly ways and means committee, on the transactions in the EHR loan fund, including but not limited to deposits to the fund, loans made from the fund, investment income, and the balance on hand as of the end of each year.

7. The commissioner is authorized, with the assistance and cooperation of the authority, to provide a program of technical assistance for eligible health care providers.

8. The commissioner may promulgate regulations, including emergency regulations, to implement the provisions of this section.

*** § 2822. Residential care off-site facility demonstration project.** 1. Notwithstanding any law to the contrary, there is hereby created a demonstration program within the department to assess reimbursement methodologies and delivery methods in conjunction with the provision of physical, occupational, and speech therapy and related education services provided by licensed professionals acting within their scope of practice and employed by a residential health care facility at an off-site facility operated by a residential health care facility. As part of the demonstration program, a selected provider shall be authorized to provide such therapy and related services for persons in need of such care.

2. The department may approve up to three providers as part of the demonstration program.

3. In order to be an eligible provider an applicant must be issued an

operating certificate for the provision of residential health care services pursuant to this article which shall include a certificate to provide on-site outpatient services and demonstrate that the provision of all physical, occupational, and speech therapy and related education services provided at the off-site facility will be in accordance with all applicable safety standards set forth in state and local law.

4. Any provider selected to participate in the demonstration program shall annually report to the department on the number of patients served, the type of services provided, the cost of such services, the sources of payment for such services, safety standards in place for the provisions of such services and such other information as required by the department to develop reimbursement methodologies and fee schedules for limited services and to determine the effectiveness of the provision of therapy and related services at an off-site facility operated by a residential health care facility. During the demonstration period, an eligible provider approved for the purposes of this section shall not have their medical assistance rates adjusted for any additional costs related to such demonstration project.

* NB Repealed June 30, 2027

§ 2823. Supportive housing development program. 1. For the purposes of this section "eligible applicant" shall mean (a) a unit of local government, or (b) a not-for-profit corporation that has been in existence for a period of at least one year prior to application and has been engaged in supportive housing programs for vulnerable populations.

2. Grants provided pursuant to this section shall be used only to fund housing development activities and other general programmatic activities to help ensure a stable system of supportive housing for vulnerable persons in the community. Reinvestment funds for supportive housing for vulnerable populations, which are general fund savings directly related to inpatient hospital and nursing home bed decertification and/or facility closure, shall be allocated annually by the commissioner based upon the following criteria:

(a) the efficiency and effectiveness of the use of funding for the

development of adequate and accessible housing to support vulnerable persons in the community and to ensure access to supports necessary to maximize expected outcomes; and

(b) other relevant factors relating to the maintenance of existing supportive housing and the development of new supportive housing and associated services.

3. The commissioner shall establish an application process by which eligible applicants may apply for a grant under this section. The application shall include:

(a) the geographic area in which the housing/services shall be provided;

(b) a detailed description of the housing/services to be provided;

(c) a plan for the efficient and effective use of funding for the development of adequate and accessible housing to support vulnerable persons in the community;

(d) other relevant factors relating to the need for maintenance of existing supportive housing and the development of new supportive housing and associated services; and

(e) any other information that the commissioner deems relevant and appropriate.

4. Grantees under this section shall file an annual report with the commissioner, in such form and with such information and data as the commissioner prescribes detailing the expenditure of grant funds. In addition, the commissioner is authorized and empowered to make inspections and examine records of any entity funded pursuant to subdivision two of this section. Such examination shall include all medical, service and financial records, receipts, disbursements, contracts, loans and other moneys relating to the financial operation of the provider.

5. The amount of supportive housing development reinvestment funds for the department shall be subject to annual appropriation. The methodologies used to calculate the savings shall be developed by the commissioner and the director of the budget. In no event shall the full annual value of supportive housing development reinvestment programs

attributable to inpatient hospital and nursing home bed decertification and/or facility closure exceed the twelve month value of the department of health general fund reductions resulting from such decertification and/or facility closure.

6. The annual supportive housing development reinvestment appropriation shall reflect a proportion of the amount of general fund savings resulting from subdivision five of this section. Within any fiscal year where appropriation increases are recommended for the supportive housing development reinvestment program, insofar as projected bed decertification and/or facility closures do not occur as estimated, and general fund savings do not result, then the reinvestment appropriations may be reduced in the next year's annual budget itemization.

7. No provision in this section shall create or be deemed to create any right, interest or entitlement to services or funds that are subject to this section, or to any other services or funds, whether to individuals, localities, providers or others, individually or collectively.

8. The commissioner shall promulgate regulations, and may promulgate emergency regulations, to effectuate the provisions of this section.

*** § 2824. Central service technicians.** 1. For the purposes of this section, the terms:

(a) "central service technician" shall mean a person who provides the services of decontamination, preparation, packaging, sterilization, and storage and distribution of reusable medical instrumentation or devices in healthcare facilities other than in the course of practicing as a healthcare professional.

(b) "healthcare facility" shall mean general hospital as defined by subdivision ten of section twenty-eight hundred one of this article or a hospital as defined by subdivision one of section twenty-eight hundred one of this article operating as a diagnostic and treatment center authorized to provide ambulatory surgical services.

(c) "healthcare professional" shall mean a person licensed or certified pursuant to title eight of the education law.

2. A person shall not function as a central service technician in a healthcare facility and a healthcare facility shall not employ or otherwise contract for the services of a central service technician unless the person meets one of the following:

(a) (i) has successfully passed a nationally accredited central service exam for central service technicians; and (ii) holds and maintains one of the following credentials administered by a nationally accredited central service technician credentialing organization: the certified registered central service technician credential, the certified sterile processing and distribution technician credential or a substantially equivalent credential; or

(b) provides evidence that the person was employed or otherwise contracted for the services as a central service technician in a healthcare facility for a cumulative period of one year, occurring within the four years immediately prior to the effective date of this section. In furtherance of this paragraph, any contractor or employer of persons functioning as a central service technician on the effective date of this section shall confirm in writing to each employee or contractor his or her employment in a capacity functioning as a central service technician in a healthcare facility as of the effective date of this section; or

(c) is a student or intern performing the functions of a central service technician if the student or intern is under the direct supervision of an appropriately licensed or certified healthcare professional and is functioning within the scope of the student's or intern's training.

3. A central service technician who does not meet the requirements of paragraph (b) of subdivision two of this section shall have eighteen months from the date of hire to obtain the certified registered central service technician credential or the certified sterile processing and distribution technician credential.

4. A person who qualifies to function as a central service technician

in a healthcare facility under paragraphs (a) and (b) of subdivision two of this section must annually complete ten hours of continuing education credits to remain qualified to function as a central service technician.

5. (a) A central service technician shall document in writing good cause that prevents compliance with the continuing education requirement as prescribed in subdivision four of this section, which shall include any of the following reasons: a medical condition which requires an extended leave of absence and is documented by an appropriate healthcare professional, or extended active duty with the armed forces of the United States. If one of these conditions is met, an extension to meeting the continuing education requirement, as prescribed in subdivision four of this section, may be granted by:

(i) the accrediting agency of a central service technician qualifying under paragraph (a) of subdivision two of this section; or

(ii) a healthcare facility employing or contracting a central service technician under paragraph (b) of subdivision two of this section.

(b) If an extension is granted, a central service technician shall complete all past due continuing education requirements within ninety days upon resolution of the medical condition or termination of extended active duty with the armed forces of the United States.

6. A healthcare facility may employ or otherwise contract with a person who does not meet the requirements of subdivision two of this section to function as a central service technician in a healthcare facility if:

(a) after a diligent and thorough effort has been made, the healthcare facility is unable to employ or contract with a sufficient number of qualified central service technicians who meet the requirements of this section;

(b) the healthcare facility makes a written record of its efforts under paragraph (a) of this subdivision and retains the record at the healthcare facility; and

(c) the person meets the requirements of paragraph (a) of subdivision two of this section within two years of the start of employment or contracting for the performance of central service technician duties.

7. A healthcare facility that employs or contracts with a central service technician shall upon request of another healthcare facility, or upon request of a central service technician employed by, formerly employed by or contracted to perform as a central service technician at the healthcare facility, verify the dates of employment or contract of such person.

8. Nothing in this section shall prohibit any healthcare professional from performing central service technicians' tasks or functions if the person is acting within the scope of his or her practice. Nothing in this section shall mean that any individual not licensed pursuant to title eight of the education law may perform tasks or functions limited to the scope of practice of a healthcare professional under such title.

9. The commissioner shall promulgate regulations as he or she may deem appropriate to effectuate the purposes of this section.

* NB There are 2 § 2824's

*** § 2824. Surgical technology and surgical technologists. 1.**

Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Healthcare facility" means a general hospital as defined by subdivision ten of section twenty-eight hundred one of this article or a hospital as defined by subdivision one of section twenty-eight hundred one of this article operating as a diagnostic and treatment center authorized to provide ambulatory surgical services.

(b) "Surgical technologist" means a person who performs surgical technology other than in the course of practicing as a healthcare professional.

(c) "Surgical technology" means the following surgery related tasks and functions:

(i) assisting healthcare professionals to prepare the operating room and sterile field for surgical procedures, including assisting healthcare professionals to set up sterile supplies, instruments and equipment using sterile technique and ensuring that surgical equipment function properly and safely;

(ii) assisting healthcare professionals to move and position patients for surgery;

(iii) assisting healthcare professionals to perform non-invasive prepping of the skin's surface and draping patients for surgery;

(iv) assisting the surgeon's provision of hemostasis during surgery by handing instruments;

(v) holding a retractor after placement by a healthcare professional;

(vi) anticipating instrument needs of a surgeon; and

(vii) other tasks incidental to surgery that do not fall within the scope of practice of a licensed profession, as directed by the surgeon. Services that fall within the practice of licensed professions include, but are not limited to:

(A) retracting tissue to expose the operating field during a surgical procedure;

(B) administering any medication by any route, including local and topical medications;

(C) placing hemostatic instruments or devices or applying cautery or tying off bleeders;

(D) applying sutures or assisting with or performing wound closure;

(E) assisting the surgeon in identifying structures that should not be ligated; and

(F) applying wound dressings.

(d) "Healthcare professional" means a person licensed or certified to practice a healthcare profession under title eight of the education law, acting within the scope of his or her practice.

2. A surgical technologist shall not perform surgical technology except under the direction and supervision of an appropriately licensed healthcare professional participating in the surgery and acting within the scope of his or her practice to direct and supervise the surgical technologist.

3. Minimum standards for certification of surgical technologists. A person may not function as a surgical technologist in a healthcare facility, and a healthcare facility shall not employ or otherwise contract for the services of a surgical technologist, unless the person meets one of the following:

(a) has successfully completed a nationally accredited educational program for surgical technologists and holds and maintains a certified surgical technologist credential administered by a nationally accredited surgical technologist credentialing organization;

(b) has completed an appropriate training program for surgical technology in the United States Army, Navy, Air Force, Marine Corps, Coast Guard or Public Health Service Commissioned Corps;

(c) provides evidence that the person was employed as a surgical technologist in a healthcare facility for a cumulative period of one year, occurring within the four years immediately prior to the effective date of this section. In furtherance of this paragraph, any employer of persons performing surgical technology on the effective date of this section shall confirm in writing to each employee his or her employment in a capacity performing surgical technology in a healthcare facility as of the effective date of this section; or

(d) is in the service of the federal government, to the extent the person is performing duties related to that service.

4. A person may be employed or contracted to practice surgical technology during the twelve month period immediately following successful completion of a surgical technology program under paragraph (a) of subdivision three of this section, but may not continue to be employed or contracted with beyond that period without documentation that the employee or contractor holds and maintains a certified surgical technologist credential required in paragraph (a) of subdivision three of this section.

5. A person who qualifies to function as a surgical technologist in a healthcare facility must annually complete fifteen hours of continuing education to remain qualified to practice as a surgical technologist. A healthcare facility that employs or contracts with a person to practice surgical technology shall verify that the person meets the continuing education requirements of this subdivision.

6. (a) A surgical technologist shall document in writing good cause that prevents compliance with the continuing education requirement as prescribed in subdivision five of this section, which shall include any

of the following reasons: a medical condition which requires an extended leave of absence and is documented by an appropriate healthcare professional, or extended active duty with the armed forces of the United States. If one of these conditions is met, an extension to meeting the continuing education requirement, as prescribed in subdivision five of this section may be granted by:

- (i) the accrediting agency of a surgical technologist qualifying under paragraph (a) of subdivision three of this section; or

- (ii) a healthcare facility for a surgical technologist under paragraph (c) of subdivision three of this section.

- (b) If an extension is granted, a surgical technologist shall complete all past due continuing education requirements within ninety days upon resolution of the medical condition or termination of extended active duty with the armed forces of the United States.

7. A healthcare facility may employ or otherwise contract with a person who does not meet the requirements of subdivision three of this section to function as a surgical technologist in a healthcare facility if:

- (a) after a diligent and thorough effort has been made, the healthcare facility is unable to employ or contract with a sufficient number of qualified surgical technologists who meet the requirements of this section;

- (b) the healthcare facility makes a written record of its efforts under paragraph (a) of this subdivision and retains the record at the healthcare facility; and

- (c) the person meets the requirements of subdivision three of this section within two years of the start of employment or contracting for the performance of surgical technology.

8. Nothing in this section shall prohibit any healthcare professional from performing surgical technology tasks or functions if the person is acting within the scope of his or her practice. Nothing in this section shall mean that any individual not licensed pursuant to title eight of the education law may perform tasks or functions limited to the scope of practice of a healthcare professional under such title.

9. A healthcare facility that employs or contracts with a surgical technologist shall, upon request of another healthcare facility, or upon request of a surgical technologist employed by, formerly employed by or contracted with to perform surgical technology tasks at the healthcare facility, verify the dates of employment or contract of such person.

10. The commissioner shall promulgate regulations as he or she may deem appropriate to effectuate the purposes of this section.

* NB There are 2 § 2824's

§ 2825. Capital restructuring financing program. 1. A capital restructuring financing program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of enhancing the quality, financial viability and efficiency of New York's health care delivery system by transforming the system into a more rational patient-centered care system that promotes population health and improved well-being for all New Yorkers. The issuance of any bonds or notes hereunder shall further be subject to the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. For the period April first, two thousand fourteen through March thirty-first, two thousand twenty-one, funds made available for expenditure pursuant to this section may be distributed by the commissioner and the president of the authority, in consultation with the commissioners of the office of mental health, office for people with developmental disabilities and office for alcoholism and substance abuse services, as applicable, for:

(a) capital grants to general hospitals, residential health care facilities, diagnostics and treatment centers, and clinics licensed pursuant to this chapter or the mental hygiene law, assisted living programs, primary care providers, and home care providers certified or licensed pursuant to article thirty-six of this chapter (collectively

"applicants") that qualify for payments under the delivery system reform incentive payment program (DSRIP), in which case funding under this paragraph shall be requested in such applicant's DSRIP application. Such capital grant projects include, but are not limited to; closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects as determined by the commissioner and the president of the authority.

(b) capital grants to general hospitals, residential health care facilities, diagnostic and treatment centers, and clinics licensed pursuant to this chapter or the mental hygiene law, assisted living programs, primary care providers, home care providers, certified or licensed pursuant to article thirty-six of this chapter (collectively "applicants") that are non-qualifying and non-participating applicants under paragraph (a) of this subdivision, for capital non-operational works or purposes that support the purposes set forth in this section. Such capital grant projects include, but are not limited to; closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services.

3. The commissioner and the president of the authority shall enter into an agreement, subject to approval by the director of the budget and subject to section sixteen hundred eighty-r of the public authorities law, as added by a chapter of the laws of two thousand fourteen, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. To the extent practicable, funds shall be awarded regionally in proportion to the applications received from the request for application issued by or before May first, two thousand fifteen. Projects awarded under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

(a) For capital grant projects under paragraph (a) of subdivision two

of this section, the evaluation of applications shall be submitted pursuant to the process described in paragraph (b) of subdivision twenty of section twenty-eight hundred seven of this article; provided, however, that such capital grant projects shall not be subject to review by the federal Centers for Medicare and Medicaid services.

(b) For monies allocated under paragraph (b) of subdivision two of this section:

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

(A) the process by which such applications shall be reviewed;

(B) the criteria by which such applications shall be judged; and

(C) a list of approved and denied applications subsequent to such determination.

(ii) the evaluation of applications shall be reviewed by the department, pursuant to a process to be determined by the department. Applications shall then be subject to review by the panel established pursuant to paragraph (b) of subdivision twenty of section twenty-eight hundred seven of this article, which shall submit its recommendations to the commissioner for final determination. Determination of awards for funds allocated under paragraph (b) of subdivision two of this section, shall include, but not be limited to the following criteria:

(A) eligibility requirements for applicants;

(B) statewide geographic distribution of funds;

(C) minimum and maximum amounts of funding to be awarded under the program;

(D) the relationship between the project proposed by an applicant and identified community need;

(E) the extent to which the applicant has access to alternative financing;

(F) the extent to which the proposed project furthers the purposes set forth in this section;

(G) the extent that the proposed project furthers the development of primary care;

(H) the extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;

(I) the extent to which the proposed project addresses potential risk to patient safety and welfare;

(J) the extent that the proposed project involves an applicant that receives or has applied for a temporary rate adjustment pursuant to applicable regulations; and

(K) the extent to which the proposed project will contribute to the long term sustainability of the applicant.

The commissioner shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall conform to the reporting requirements of subdivision twenty of section twenty-eight hundred seven of this article, as applicable.

§ 2825-a. Health care facility transformation program: Kings county project. 1. A Kings county health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide capital funding in support of projects that replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity intended to create a financially sustainable system of care. The issuance of any bonds or notes hereunder shall be subject to the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner and the president of the authority for capital grants to general hospitals, residential health

care facilities, diagnostic and treatment centers, primary care providers, and home care providers, certified or licensed pursuant to article thirty-six of this chapter, for capital non-operational works or purposes that support the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of budget no later than thirty days prior to the release of a request for applications for funding under this program. Projects awarded under section twenty-eight hundred twenty-five of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to seven hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for capital grants to health care providers (hereafter "applicants") located in the county of Kings.

(a) Eligible applicants shall serve communities whose residents are experiencing significant levels of health care disparities and health care needs compared to other communities within the county of Kings as evidenced by:

- (i) a high number of Medicaid enrollees and uninsured individuals;
- (ii) elevated blood lead level rates among children, high rates of diabetes, high blood pressure, asthma, obesity, infant death or premature birth, heart failure, behavioral health conditions, substance abuse;
- (iii) low levels of income, high rates of unemployment, distressed housing conditions, and poor nutritional status;
- (iv) other risk factors as determined by the commissioner and the president of the authority; and

(b) Such eligible applicant shall:

- (i) (A) have a loss from operations for each of the three consecutive preceding years as evidenced by audited financial statements;
- (B) have a negative fund balance or negative equity position in each of the three preceding years as evidenced by audited financial statements; and

(C) have a current ratio of less than 1:1 for each of three consecutive preceding years; or

(ii) be deemed by the commissioner and president of the authority to be a provider that fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community.

4. In determining awards for eligible applicants under this section, the commissioner and the president of the authority shall consider criteria including, but not limited to:

(a) the extent to which the proposed capital project will contribute to the long term sustainability of the applicant or preservation of essential health services in the community or communities served by the applicant;

(b) the extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals and objectives;

(c) the relationship between the proposed capital project and identified community need;

(d) the extent that the proposed capital project furthers the development of primary care and other outpatient services;

(e) the extent to which the proposed capital project benefits Medicaid enrollees and uninsured individuals;

(f) the extent to which the applicant has engaged the community affected by the proposed capital project and the manner in which community engagement has shaped such capital project; and

(g) the extent to which the proposed capital project addresses potential risk to patient safety and welfare.

5. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall conform to the reporting requirements of subdivision twenty of section twenty-eight hundred seven of this article, as applicable.

§ 2825-b. Oneida county health care facility transformation program: Oneida county project. 1. An Oneida county health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide capital funding in support of projects located in the largest population center in Oneida county that consolidate multiple licensed health care facilities into an integrated system of care. The issuance of any bonds or notes hereunder shall be subject to the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner and the president of the authority for capital grants to general hospitals for the purposes of consolidating multiple licensed health care facilities into an integrated system of care for capital non-operational works or purposes that support the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of budget no later than thirty days prior to the release of a request for applications for funding under this program. Projects awarded under section twenty-eight hundred twenty-five of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to three hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal

process for capital grants to health care providers (hereafter "applicants") located in the county of Oneida.

4. In determining awards for eligible applicants under this section, the commissioner and the president of the authority shall consider criteria including, but not limited to:

(a) the extent to which the proposed capital project will contribute to the integration of health care services and long term sustainability of the applicant or preservation of essential health services in the community or communities served by the applicant;

(b) the extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals and objectives;

(c) the relationship between the proposed capital project and identified community need;

(d) the extent that the proposed capital project furthers the development of primary care and other outpatient services;

(e) the extent to which the proposed capital project benefits Medicaid enrollees and uninsured individuals;

(f) the extent to which the applicant has engaged the community affected by the proposed capital project and the manner in which community engagement has shaped such capital project; and

(g) the extent to which the proposed capital project addresses potential risk to patient safety and welfare.

5. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall conform to the reporting requirements of subdivision twenty of section twenty-eight hundred seven of this article, as applicable.

§ 2825-c. Essential health care provider support program. 1.

Notwithstanding section one hundred sixty-three of the state finance law, or any inconsistent provision of law to the contrary, within amounts appropriated, funds may be allocated and distributed by the

commissioner without a competitive bid or request for proposal process, for grants to essential health care providers to support debt retirement, capital projects or non-capital projects that facilitate health care transformation, including mergers, consolidation, and restructuring activities intended to create a financially sustainable system of care. Grants shall not be available to support general operating expenses. For purposes of this section, an essential health care provider is a hospital or hospital system that, in the discretion of the commissioner, offers health care services within a defined geographic region where such services would otherwise be unavailable to the population of such region.

2. The commissioner shall award grants for projects consistent with the purposes of this section. Eligible applicants shall meet the following criteria:

(a) (i) have a loss from operations for each of the three consecutive preceding years as evidenced by audited financial statements;

(ii) have a negative fund balance or negative equity position in each of the three preceding years as evidenced by audited financial statements; and

(iii) have a current ratio of less than 1:1 for each of three consecutive preceding years; or

(b) be deemed by the commissioner to be a provider that fulfills or will fulfill an unmet need for acute inpatient, outpatient, primary or residential health care services in a defined geographic region where such services would be otherwise unavailable to the population of such region.

3. Such awards shall be distributed pursuant to criteria, including but not limited to:

(a) the extent to which the proposed project will contribute to the long term sustainability of the applicant or preservation of essential health care services in a community;

(b) the extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals and objectives;

(c) consideration of geographic distribution of funds;

- (d) the relationship between the proposed project and an identified community need;
- (e) the extent to which the applicant has access to alternative financing;
- (f) the extent to which the proposed project furthers the development of primary care;
- (g) the extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;
- (h) the extent to which the applicant has engaged the community affected by the proposed project and the manner in which the community engagement has shaped such project; and
- (i) the extent to which the proposed project addresses potential risk to patient safety and welfare.

4. Disbursement of awards made pursuant to this section shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined in the sole discretion of the commissioner. Such metrics and milestones shall be structured to ensure that the health care transformation and provider sustainability goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

5. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision four of this section.

§ 2825-d. Health care facility transformation program: statewide. 1. A statewide health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the

purpose of strengthening and protecting continued access to health care services in communities. The program shall provide capital funding in support of projects that replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity that is part of an overall transformation plan intended to create a financially sustainable system of care. The issuance of any bonds or notes hereunder shall be subject to section sixteen hundred eighty-r of the public authorities law and the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner and the president of the authority for capital grants to general hospitals, residential health care facilities, diagnostic and treatment centers and clinics licensed pursuant to this chapter or the mental hygiene law, for capital non-operational works or purposes that support the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of budget no later than thirty days prior to the release of a request for applications for funding under this program. Priority shall be given to projects not funded, in whole or in part, under section twenty-eight hundred twenty-five or twenty-eight hundred twenty-five-c of this article. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to

two hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for capital grants to health care providers (hereafter "applicants"). Provided however that a minimum of thirty million dollars of total awarded funds shall be made to community-based health care providers, which, for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; an alcohol and substance abuse treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; primary care providers; or a home care provider certified or licensed pursuant to article thirty-six of this chapter. Eligible applicants shall be those deemed by the commissioner to be a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community.

4. In determining awards for eligible applicants under this section, the commissioner and the president of the authority shall consider criteria including, but not limited to:

(a) the extent to which the proposed capital project will contribute to the integration of health care services and long term sustainability of the applicant or preservation of essential health services in the community or communities served by the applicant;

(b) the extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals and objectives;

(c) consideration of geographic distribution of funds;

(d) the relationship between the proposed capital project and identified community need;

(e) the extent to which the applicant has access to alternative financing;

(f) the extent that the proposed capital project furthers the development of primary care and other outpatient services;

(g) the extent to which the proposed capital project benefits Medicaid enrollees and uninsured individuals;

(h) the extent to which the applicant has engaged the community affected by the proposed capital project and the manner in which community engagement has shaped such capital project; and

(i) the extent to which the proposed capital project addresses potential risk to patient safety and welfare.

5. Disbursement of awards made pursuant to this section shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined in the sole discretion of the commissioner. Such metrics and milestones shall be structured to ensure that the health care transformation and provider sustainability goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

6. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision five of this section.

§ 2825-e. Health care facility transformation program: statewide II.

1. A statewide health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide funding in support of capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including, but not limited to, merger, consolidation, acquisition or other activities intended to create financially sustainable systems of care or preserve or expand essential health care services. Grants shall not be available to support general operating expenses. The issuance of

any bonds or notes hereunder shall be subject to section sixteen hundred eighty-r of the public authorities law and the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the dormitory authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner for capital grants to general hospitals, residential health care facilities, diagnostic and treatment centers and clinics licensed pursuant to this chapter or the mental hygiene law, and community-based health care providers as defined in subdivision three of this section for works or purposes that support the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days prior to the release of a request for applications for funding under this program. Priority shall be given to new applications for projects not funded under section twenty-eight hundred twenty-five-d of this article. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to five hundred million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of seventy-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a

diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; an alcohol and substance abuse treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider or a home care provider certified or licensed pursuant to article thirty-six of this chapter; or other purposes and community-based providers designated by the commissioner pursuant to information obtained pursuant to subdivision four-a of this section. Eligible applicants shall be those deemed by the commissioner to be a provider that fulfills or will fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community.

4. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may award up to three hundred million dollars of the funds made available pursuant to this section for unfunded project applications submitted in response to the request for applications number 1607010255 issued by the department on July twentieth, two thousand sixteen pursuant to section twenty-eight hundred twenty-five-d of this article, provided however that the provisions of subdivision three of this section shall apply.

4-a. Authorized amounts to be awarded pursuant to applications submitted in response to the request for application number 1607010255 shall be awarded no later than May first, two thousand seventeen. The commissioner shall not issue a request for application for the remaining appropriated amounts on or before June first, two thousand seventeen to allow stakeholder, community, and legislative input regarding program eligibility, award criteria and the process by which the remaining funds will be awarded.

5. In determining awards for eligible applicants under this section, the commissioner shall consider stakeholder, community, and legislative input pursuant to subdivision four-a of this section, and other criteria including, but not limited to:

(a) The extent to which the proposed project will contribute to the integration of health care services or the long term sustainability of the applicant or preservation of essential health services in the community or communities served by the applicant;

(b) The extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals and objectives;

(c) Consideration of geographic distribution of funds;

(d) The relationship between the proposed project and identified community need;

(e) The extent to which the applicant has access to alternative financing;

(f) The extent that the proposed project furthers the development of primary care and other outpatient services;

(g) The extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;

(h) The extent to which the applicant has engaged the community affected by the proposed project and the manner in which community engagement has shaped such project; and

(i) The extent to which the proposed project addresses potential risk to patient safety and welfare.

6. Disbursement of awards made pursuant to this section shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined in the sole discretion of the commissioner. Such metrics and milestones shall be structured to ensure that the goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

7. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant

to subdivision five of this section.

§ 2825-f. Health care facility transformation program: statewide III.

1. A statewide health care facility transformation program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York for the purpose of strengthening and protecting continued access to health care services in communities. The program shall provide funding in support of capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including, but not limited to, merger, consolidation, acquisition or other activities intended to: (a) create financially sustainable systems of care; (b) preserve or expand essential health care services; (c) modernize obsolete facility physical plants and infrastructure; (d) foster participation in alternative payment arrangements including, but not limited to, contracts with managed care plans and accountable care organizations; (e) for residential health care facilities, increase the quality of resident care or experience; or (f) improve health information technology infrastructure, including telehealth, to strengthen the acute, post-acute and long-term care continuum. Grants shall not be available to support general operating expenses. The issuance of any bonds or notes hereunder shall be subject to section sixteen hundred eighty-r of the public authorities law and the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. The commissioner and the president of the dormitory authority shall enter into an agreement, subject to approval by the director of the budget, and subject to section sixteen hundred eighty-r of the public authorities law, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section. Such funds may be distributed by the commissioner for grants to general hospitals, residential health care facilities, adult care facilities licensed under title two of article seven of the social services law,

diagnostic and treatment centers and clinics licensed pursuant to this chapter or the mental hygiene law, children's residential treatment facilities licensed pursuant to article thirty-one of the mental hygiene law, assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law, and community-based health care providers as defined in subdivision three of this section for grants in support of the purposes set forth in this section. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days prior to the release of a request for applications for funding under this program. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to five hundred twenty-five million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of: (a) sixty million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; or hospices licensed or granted an operating certificate pursuant to article forty of this chapter and (b) forty-five million dollars of the total awarded funds shall be made to residential health care facilities.

4. Notwithstanding any inconsistent subdivision of this section or any other provision of law to the contrary, the commissioner, with the approval of the director of the budget, may expend up to twenty million dollars of the funds appropriated for this program pursuant to subdivision three of this section, not including funds dedicated for community-based health care providers under paragraph (a) of such subdivision or for residential health care facilities under paragraph (b) of such subdivision, for awards made pursuant to paragraph (l) of subdivision three of section four hundred sixty-one-l of the social services law, provided that funding shall be prioritized for awards made pursuant to subparagraph (i) of such paragraph, with remaining funding available for awards made pursuant to subparagraphs (ii) and (iii) of such paragraph.

4-a. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may, subject to the availability of lawful appropriation, award up to three hundred million dollars of the funds made available pursuant to this section for unfunded project applications submitted in response to the request for applications number 17648 issued by the department on January eighth, two thousand eighteen pursuant to section twenty-eight hundred twenty-five-e of this article, provided however that the provisions of subdivisions three and four of this section shall apply.

4-b. Authorized amounts to be awarded pursuant to applications submitted in response to the request for application number 17648 shall be awarded no later than September first, two thousand nineteen.

5. In determining awards for eligible applicants under this section, the commissioner shall consider criteria including, but not limited to:

(a) the extent to which the proposed project will contribute to the integration of health care services or the long term sustainability of the applicant or preservation of essential health services in the community or communities served by the applicant;

(b) the extent to which the proposed project or purpose is aligned with delivery system reform incentive payment ("DSRIP") program goals

and objectives;

(c) the geographic distribution of funds;

(d) the relationship between the proposed project and identified community need;

(e) the extent to which the applicant has access to alternative financing;

(f) the extent to which the proposed project furthers the development of primary care and other outpatient services;

(g) the extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;

(h) the extent to which the applicant has engaged the community affected by the proposed project and the manner in which community engagement has shaped such project; and

(i) the extent to which the proposed project addresses potential risk to patient safety and welfare.

6. Disbursement of awards made pursuant to this section shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined in the sole discretion of the commissioner. Such metrics and milestones shall be structured to ensure that the goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

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

§ 2825-g. Health care facility transformation program: statewide IV.

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

2. The commissioner shall enter into an agreement with the president of the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution and administration of available funds pursuant to such agreement, and made available pursuant to this section and appropriation. Such funds may be awarded and distributed by the department for grants to health care providers including but not limited to, hospitals, residential health care facilities, adult care facilities licensed under title two of article seven of the social services law, diagnostic and treatment centers licensed or granted an operating certificate under this chapter, clinics, including but not limited to those licensed or granted an operating certificate under this chapter or the mental hygiene law, children's residential treatment facilities licensed under article thirty-one of the mental hygiene law, assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law, behavioral health facilities licensed or granted an operating certificate pursuant to articles thirty-one and thirty-two of the mental hygiene law, home care providers certified or licensed under article thirty-six of this chapter, primary care providers, hospices licensed or granted an operating certificate pursuant to article forty of this chapter, community-based programs funded under the office of mental health, the office of addiction services and supports, the office for people with developmental disabilities, or through local governmental units as defined under article forty-one of the mental hygiene law, independent practice associations or organizations, and residential facilities or day program facilities licensed or granted an

operating certificate under article sixteen of the mental hygiene law. A copy of such agreement, and any amendments thereto, shall be provided by the department to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days after such agreement is finalized. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

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

(a) twenty-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as diagnostic and treatment centers licensed or granted an operating certificate under this chapter; independent practice associations or organizations; home care providers certified or licensed pursuant to article thirty-six of this chapter; and hospices licensed or granted an operating certificate pursuant to article forty of this chapter;

(b) twenty-five million dollars of total awarded funds shall be made to a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; alcohol and substance use disorder treatment clinics licensed or granted an operating certificate under article thirty-two of the mental hygiene law; clinics licensed or granted an operating certificate under article sixteen of the mental hygiene law; and community-based programs funded

under the office of mental health or the office of addiction services and supports or through local governmental units as defined under article forty-one of the mental hygiene law; and

(c) fifty million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities licensed under title two of article seven of the social services law.

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

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

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

(c) Provided, however, that a minimum of:

(i) twenty-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as diagnostic and treatment centers licensed or granted an operating certificate pursuant to this chapter; independent practice associations or organizations; home care providers certified or licensed pursuant to article thirty-six of this chapter; and hospices licensed or granted an operating certificate pursuant to article forty of this chapter;

(ii) twenty-five million dollars of total awarded funds shall be made to a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; alcohol and substance use disorder treatment clinics licensed or granted an operating certificate under article thirty-two of the mental hygiene law; clinics licensed or granted an operating certificate under article sixteen of the mental hygiene law; and community-based programs funded under the office of mental health or the office of addiction services and supports or through local governmental units as defined under article forty-one of the mental hygiene law; and

(iii) twenty-five million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities licensed under title two of article seven of the social services law.

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

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

residential and community-based alternatives to the traditional model of nursing home care.

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

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

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

2. The commissioner shall enter into an agreement with the president of the dormitory authority of the state of New York pursuant to section

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

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

4. Notwithstanding section one hundred sixty-three of the state finance law, or any inconsistent provision of law to the contrary, up to five hundred million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for technological and telehealth transformation projects, which shall include projects related to improving cyber security, and which may also include unfunded project applications submitted in response to a request for applications issued by the department pursuant to subdivision six of section twenty-eight hundred twenty-five-g of this article.

5. Selection of awards made by the department pursuant to subdivisions three and four of this section shall be contingent on an evaluation process acceptable to the commissioner and approved by the director of the division of the budget. Disbursement of awards shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined by the commissioner. Such metrics and milestones shall be structured to ensure that the goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner.

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

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

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

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

(ii) the type of collaborative model proposed, including but not

limited to a merger, acquisition, management services contract, or clinical integration;

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

(iv) a timeline of key metrics and goals;

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

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

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

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

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

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

or medical assistance program dually-eligible individuals;

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

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

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

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

5. Notwithstanding any provision of law to the contrary, the commissioner may waive regulatory requirements to allow applicants to more effectively or efficiently implement projects awarded through the healthcare safety net transformation program, provided, however, that regulations pertaining to minimum standards for hospitals for patient safety, patient autonomy, patient privacy, patient rights, quality of care, safe staffing, adverse event reporting, due process, scope of practice, professional licensure, environmental protections, infection control, provider reimbursement methodologies, character and competence, or occupational standards and employee rights shall not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the commissioner may determine. Any regulatory

relief granted pursuant to this subdivision shall be specifically described and requested within each project application and be reviewed by the commissioner.

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

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

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

§ 2826. Temporary adjustment to reimbursement rates. (a)

Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however,

that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

- (i) providers undergoing closure;
- (ii) providers impacted by the closure of other health care providers;
- (iii) providers subject to mergers, acquisitions, consolidations or restructuring; or
- (iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

- (i) protect or enhance access to care;
- (ii) protect or enhance quality of care;
- (iii) improve the cost effectiveness of the delivery of health care services; or
- (iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

- (i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;
- (ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;
- (iii) The extent to which such application will involve savings to the Medicaid program;
- (iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;
- (v) The extent to which such applicant is geographically isolated in

relation to other providers; or

(vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and

the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this

paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within

amounts appropriated for such purposes as described herein, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible facilities with serious financial instability and requiring extraordinary financial assistance to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Provided, however, the commissioner is authorized to make such a temporary adjustment or make such temporary lump sum payment only pursuant to criteria, an application, and an evaluation process acceptable to the commissioner in consultation with the director of the division of the budget. The department shall publish on its website the criteria, application, and evaluation process and notification of any award recipients.

(i) Eligible facilities shall include:

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

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital;

(D) a residential health care facility;

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

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

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

(3) such hospital that, in the discretion of the commissioner, serves a significant population of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(F) an independent practice association or accountable care organization authorized under applicable regulations that participate in managed care provider network arrangements with any of the provider

types in subparagraphs (A) through (F) of this paragraph; or an entity that was formed as a preferred provider system pursuant to the delivery system reform incentive payment (DSRIP) program and collaborated with an independent practice association that received VBP innovator status from the department for purposes of meeting DSRIP goals, and which preferred provider system remains operational as an integrated care system.

(ii) Eligible applicants must demonstrate that without such award, they will be in serious financial instability, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Eligible applicants shall submit a completed application to the department.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) criteria or requirements upon which an award of funds shall be conditioned, such as a transformation plan, savings plan or quality improvement plan. In the event the department requires an applicant to

enter into an agreement or contract with a vendor or contractor, the department shall approve the selected vendor or contractor but shall not specify the vendor or contractor that the applicant must utilize; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department may make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment; or

(B) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision that are made on a monthly basis will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

§ 2827. Plant-based food options. 1. Upon request by a patient or the patient's lawful representative in a hospital providing inpatient or residential care, the hospital shall offer the patient a plant-based food option as an alternative to every meal or snack offered in food service to the patient. All the hospital's written material describing

food offerings shall include the availability of a plant-based food option. The plant-based food option shall be offered at no additional cost to the patient beyond what would be charged for a comparable non-plant-based food option.

2. The hospital shall respond in a reasonable manner and time to any request made under this section. The request shall be effective for every hospital meal or snack in which the patient is reasonably expected to participate. This section does not preclude the offering of plant-based food options to patients who have not requested it, and does not preclude an individual who has requested a plant-based food option from selecting a non-plant-based food option.

3. As used in this section:

(a) "Plant-based food option" means a food or beverage that is free of animal products and that has nutritional value comparable to the non-plant-based food option that it replaces.

(b) "Animal product" means meat, poultry, seafood, dairy, eggs, honey, and any derivative thereof.

4. This section shall not apply to patient nutritional support products including, but not limited to, infant formulas, nutritional modulars, oral nutritional supplements, enteral nutrition formulas, and parenteral or intravenous nutrition, prescribed or ordered by a health care professional, licensed, certified or otherwise authorized to practice under title eight of the education law, acting within the professional's lawful scope of practice. However, where a request is made under subdivision one of this section, and a health care professional is considering prescribing or ordering a patient nutritional support product under this subdivision, the health care professional shall consider and advise the requester whether a medically suitable plant-based food option is reasonably available.

*** § 2828. Residential health care facilities; minimum direct resident care spending.** 1. (a) Notwithstanding any law to the contrary, the department shall promulgate regulations governing the disposition of

revenue in excess of expenses for residential health care facilities consistent with this section. Beginning on and after January first, two thousand twenty-two, every residential health care facility shall spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue shall be spent on resident-facing staffing, provided that amounts spent on resident-facing staffing shall be included as a part of amounts spent on direct resident care.

(b) Fifteen percent of costs associated with resident-facing staffing contracted out by a facility for services provided by registered professional nurses or licensed practical nurses licensed pursuant to article one hundred thirty-nine of the education law or certified nurse aides who have completed certification and training approved by the department shall be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care.

(c) (i) Except as provided in subparagraph (ii) of this paragraph, such regulations shall further include at a minimum that any residential health care facility for which total operating revenue exceeds total operating and non-operating expenses by more than five percent of total operating and non-operating expenses or that fails to spend the minimum amount necessary to comply with the minimum spending standards for resident-facing staffing or direct resident care, calculated on an annual basis, or for the year two thousand twenty-two, on a pro-rata basis for only that portion of the year during which the failure of a residential health care facility to spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue on resident-facing staffing, may be held to be a violation of this chapter, shall remit such excess revenue, or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as the case may be, to the state, with such excess revenue which shall be payable, in a manner to be determined by such regulations, by November first in the year following the year in which the expenses are incurred. The department shall collect such payments by methods including, but not limited to, bringing suit in a court of competent jurisdiction on its own behalf after giving notice of such suit to the attorney general, deductions or offsets from payments made pursuant to the Medicaid program, and shall deposit such recouped funds into the nursing home quality pool, as set

forth in paragraph (d) of subdivision two-c of section twenty-eight hundred eight of this article. Provided further that such payments of excess revenue shall be in addition to and shall not affect a residential health care facility's obligations to make any other payments required by state or federal law into the nursing home quality pool, including but not limited to medicaid rate reductions required pursuant to paragraph (g) of subdivision two-c of section twenty-eight hundred eight of this article and department regulations promulgated pursuant thereto. The commissioner or their designees shall have authority to audit the residential health care facilities' reports for compliance in accordance with this section.

(ii) Notwithstanding the requirements prescribed by subparagraph (i) of this paragraph, the provisions of a demonstration project established pursuant to a chapter of the laws of two thousand twenty-three that amended this subparagraph shall apply to those residential health care facilities who qualify for such demonstration project.

2. For the purposes of this section the following terms shall have the following meanings:

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

(i) the capital portion of the Medicaid reimbursement rate;

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

(iii) any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including but not limited to funds received from the federal emergency management agency or health resources and services administration.

(b) "Expenses" shall include all operating and non-operating expenses,

before extraordinary gains, reported in cost reports submitted pursuant to section twenty-eight hundred five-e of this article, except as expressly excluded by regulations and/or this section. Such exclusions shall include, but not be limited to, any related party transaction or compensation to the extent that the value of such transaction is greater than fair market value, and the payment of compensation for employees who are not actively engaged in or providing services at the facility.

(c) "Direct resident care" includes the following cost centers in the residential health care facility cost report: (i) Nonrevenue Support Services - Plant Operation & Maintenance, Laundry and Linen, Housekeeping, Patient Food Service, Nursing Administration, Activities Program, Nonphysician Education, Medical Education, Medical Director's Office, Housing, Social Service, Transportation; (ii) Ancillary Services - Laboratory Services, Electrocardiology, Electroencephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Psychiatric, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy, Pharmacy, Central Services Supply, Medical Staff Services provided by licensed or certified professionals including and without limitation Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant; and (iii) Program Services - Residential Health Care Facility, Pediatric, Traumatic Brain Injury (TBI), Autoimmune Deficiency Syndrome (AIDS), Long Term Ventilator, Respite, Behavioral Intervention, Neurodegenerative, Adult Care Facility, Intermediate Care Facilities, Independent Living, Outpatient Clinics, Adult Day Health Care, Home Health Care, Meals on Wheels, Barber & Beauty Shop, and Other similar program services that directly address the physical conditions of residents. Direct resident care does not include, at a minimum and without limitation, administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, and fiscal services.

(d) "Resident-facing staffing" shall include all staffing expenses in the ancillary and program services categories on exhibit h of the residential health care reports as in effect on February fifteenth, two thousand twenty-one.

(e) "Cost Report" shall mean the annual financial and statistical report submitted to the department pursuant to sections two thousand

eight hundred five-e and two thousand eight hundred eight-b of this article, and regulations promulgated pursuant thereto, which includes the residential health care facility's revenues, expenses, assets, liabilities and statistical information.

3. For the purposes of this section, residential health care facilities shall not include (a) facilities that are authorized by the department to primarily care for medically fragile children, people with HIV/AIDS, persons requiring behavioral intervention, persons requiring neurodegenerative services, and other specialized populations that the commissioner deems appropriate to exclude; and (b) continuing care retirement communities licensed pursuant to article forty-six or forty six-a of this chapter.

4. The commissioner may waive the requirements of this section on a case-by-case basis with respect to a nursing home that demonstrates to the commissioner's satisfaction that it experienced unexpected or exceptional circumstances that prevented compliance. The commissioner may also exclude from revenues and expenses, on a case-by-case basis, extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances set forth by the commissioner in regulation. At least thirty days before any action by the commissioner under this subdivision, the commissioner shall transmit the proposed action to the state office of the long-term care ombudsman and the chairs of the senate and assembly health committees, and post it on the department's website.

5. The commissioner shall issue regulations, seek amendments to the state plan for medical assistance, seek waivers from the federal Centers for Medicare and Medicaid Services, and take such other actions as reasonably necessary to implement this section.

6. The commissioner shall, if necessary, update reporting forms completed by residential health care facilities under section twenty-eight hundred five-e of this article to include information to ensure all items referred to in this section and organize such information consistent with the terms of this section.

* NB There are 2 § 2828's

*** § 2828. Essential support persons allowed for individuals with disabilities during a state of emergency.** 1. For purposes of this section, the following terms shall have the following meanings:

(a) "Disability" shall mean any condition or disorder which prevents or makes difficult for an individual the ability to communicate a medical condition or certain specific medical or everyday needs, including, but not limited to, autism or cerebral palsy.

(b) "Essential support person" shall mean an individual who frequently accompanies and assists an individual with a disability with managing and communicating basic or medical needs and is considered a critical member of such individual's health care team.

2. (a) No general hospital shall establish any rules or regulations in response to a pandemic or state disaster emergency declared by the governor, prohibiting a patient who suffers from a disability from having access to an essential support person for the duration of their hospitalization from intake to discharge.

(b) An individual with a disability or the legal guardian for the individual shall be allowed to designate a single primary essential support person to assist with communicating medical needs and managing everyday needs during hospitalization and such essential support person shall be limited to such individual's parent, spouse or caretaker.

* NB There are 2 § 2828's

§ 2829. Nursing homes; disclosure requirements. 1. A nursing home shall post maximum rates to be charged for residency and services on a publicly accessible website. Such posting shall be updated on an annual basis no later than April first of each year. Such posting shall detail rates for each non-governmental payer source.

2. A nursing home shall:

(a) publicly list all owners on a website maintained by the facility and shall submit such list to the department for posting on its website

and update such information within thirty days of any change or transaction affecting ownership;

(b) publicly disclose on such facility's website and regularly update the name and business address of any landlord of such facility's premises; and

(c) publicly provide a summary of all contracts for provision of goods or services for which such facility pays with any portion of Medicaid or Medicare funds or other agreements entered into by the nursing home on its website within thirty days of execution of such agreement or contract.

3. The commissioner may make regulations necessary or appropriate to implement this section.

*** § 2830. Surgical smoke evacuation.** Every general hospital and ambulatory surgery facility licensed under this article shall adopt and implement policies to prevent exposure to surgical smoke through the use of an airborne contaminant evacuation system for each procedure that generates surgical smoke. This section does not apply to a facility that does not perform procedures that generate surgical smoke. As used in this section, "surgical smoke" means the by-product that is generated from the use of an energy generating surgical device, including, but shall not be limited to, surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, and lung damaging dust. As used in this section, "airborne contaminant evacuation system" means smoke evacuation equipment and technologies designed to capture, filter and remove surgical smoke at the site of origin and before the surgical smoke makes ocular contact or contact with the respiratory tract of any individual.

* NB There are 2 § 2830's

*** § 2830. Regulation of the billing of facility fees.** 1. For the purposes of this section, "fee" means any amount charged or billed by a provider for professional health care services provided in a hospital-based facility.

2. No hospital or health system or health care provider shall bill or seek payment from a patient for a facility fee that is not covered by the patient's health insurance carrier unless the patient was notified prior to the date of service that a facility fee would be applicable. If a health care provider enters into a business relationship with a hospital or health system that will result in the provider's patients being subject to facility fees, the health care provider must notify its patients of the change and that facility fees will now be applicable to services received from the health care provider. The notice shall be provided in writing at least seven days in advance of each date of service and shall explain the amount of the fee, the purpose of the fee, whether the patient's insurance plan will pay the fee, and for uninsured patients, how to apply for financial assistance. If advance written notice is infeasible because the visit was secured less than seven days in advance, then a written notice shall be provided on the date the service is rendered. The notice shall be provided in plain language in conspicuous twelve-point bold face type and shall be available in the top six languages spoken in the hospital's service area. In no event shall a facility fee be charged for services related to the provision of preventive care service as defined by the United States Preventive Services Task Force.

* NB There are 2 § 2830's

§ 2831. Medically fragile young adults. 1. For purposes of this section, "medically fragile young adults" shall mean individuals who meet the definition of children with medical fragility, but for the fact such individuals are aged between twenty-one and thirty-five years old.

2. The department shall promulgate rules and regulations to allow medically fragile young adults who reside in pediatric specialized nursing facilities to remain at such facilities. Unless a higher reimbursement rate is expressly authorized by the department, the reimbursement rate and methodology for such medically fragile young adults shall remain the same as it was prior to reaching age twenty-one and shall include a daily per diem rate and coverage for bed holds.

Medicaid reimbursement for this population for reserved beds due to hospitalization and for therapeutic and hospice leaves of absence must remain at one hundred percent of the Medicaid rate of medically fragile children, without any daily limit for this population.

3. This section shall be effective if, and as long as, federal financial participation is available therefor.

§ 2832. Violence prevention program. 1. For the purposes of this section, the term "facility" shall mean a general hospital or a nursing home as defined in section twenty-eight hundred one of this article.

2. Within twelve months of the effective date of this section, every facility shall establish a workplace violence prevention program. Such program in a general hospital shall be consistent with regulatory requirements including the Centers for Medicare and Medicaid Services Hospital Conditions of Participation regarding caring for patients in a safe setting 42 CFR § 482.13(c)(2), and emergency preparedness 42 CFR § 482.15(a) and (d)(1), and the workplace violence standards of any accrediting organization deemed by the Centers for Medicare and Medicaid Services under which such hospital maintains accreditation provided however, such standards are comparable to those established by The Joint Commission. The purpose of such a program shall be to protect health care workers, patients, facility residents, and visitors. The program shall, at a minimum, include the requirements set forth in this section.

3. Beginning January first, two thousand twenty-seven, all general hospitals shall conduct, not less than annually, a workplace safety and security assessment and develop a safety and security plan that addresses identified workplace violence threats or hazards. As part of the plan, a general hospital shall adopt security measures and policies, including personnel training policies designed to prevent or minimize identified workplace violence threats or hazards and protect employees, patients, and visitors from aggressive or violent behavior, including but not limited to, credible threats, assaults, injuries, and deaths. In conducting the assessment and developing the plan, general hospitals

shall ensure the active involvement of employees, including the recognized collective bargaining agent or agents, if any, and may do so through established general hospital safety and security committees and existing labor management committees. Nothing in this section shall diminish, supplant or restrict the rights, privileges and remedies of any employee or collective bargaining representative under applicable law, rule or regulation or under the terms of a collective bargaining agreement.

4. The safety and security assessment shall be tailored to the size, complexity, and local geographical factors affecting the general hospital and shall identify and consider relevant threats and hazards, including but not limited to workplace violence incident reports and incident logs, concerns or complaints raised by employees, patients, visitors and recognized collective bargaining representatives, safety and security considerations relating to the general hospital's layout and access points, visitor management, and protective factors such as access control, engineering controls to limit violence or protect employees, alarms and communication systems, and other relevant factors, as appropriate to the general hospital. Additionally, the assessment shall consider the adequacy of employee training policies and security procedures, including the handling of disruptive or violent patients and other persons. Health care workers regularly assigned to provide security in general hospital settings shall be trained regarding the role of security in overall hospital operations.

5. Based on the findings and ongoing review of the workplace violence assessment, general hospitals shall implement a workplace violence safety and security plan, which shall be updated as necessary to address newly identified material risks and changes in conditions. The safety and security plan shall specify methods to reduce identified risks, which may include employee training, increased staffing and security, engineering controls such as barriers, lighting, alarms and communication systems, safety equipment, general hospital improvements or modifications, and other appropriate measures relevant to the general hospital. Each general hospital shall provide a written detailed summary of the safety and security plan to its employees and collective

bargaining representatives, if applicable. Each general hospital shall also provide information to its employees and collective bargaining representatives, if applicable, about how to report incidents of workplace violence. Each general hospital shall share summaries of the incident log, appropriately redacted to protect the privacy of persons involved in an incident, trends and analysis of relevant data with the general hospital security or safety committee responsible for workplace violence and ensure that the data is part of the workplace violence assessment process.

6. Notwithstanding any provision of this section, compliance by a nursing home with the federal regulations 42 CFR 483.71(a)(3) and (b)(1), and 42 CFR 483.73(a)(1), governing nursing homes shall satisfy the requirements of this section for such facilities, provided that such assessments and plans address workplace violence threats and hazards.

§ 2832-a. Emergency department security. 1. A general hospital located in a city or county with a population of one million or more shall be required to have at least one off-duty law enforcement officer or trained security personnel be present at all times in the emergency department, subject to emergent circumstance in any hospital that requires an adjustment in personnel.

2. A general hospital located in a city or county with a population less than one million shall be required to have at least one off-duty law enforcement officer or trained security personnel on premises at all times in a manner that prioritizes physical presence near, or within close proximity to, the emergency department of such hospital with direct responsibility to the emergency department. This shall not apply to hospitals designated as critical access hospitals, sole community hospitals, or rural emergency hospitals. However, if any such hospital experiences increased rates of violence or abuse of emergency department personnel, by an amount to be determined by the commissioner, evidenced by internal reporting pursuant to the violence prevention program or reports to law enforcement the commissioner shall work with the critical access hospital, sole community hospital, or rural emergency hospital to

come into compliance with the requirement, to have at least one off-duty law enforcement officer or trained security personnel on premises at all times in a manner that prioritizes physical presence near, or within close proximity to, the emergency department of such hospital with direct responsibility to the emergency department, over a reasonable period of time.

ARTICLE 28-A
NURSING HOME COMPANIES

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§ 2850. Short title. This article shall be known, and may be cited and referred to as the "nursing home companies law".

§ 2851. Policy and purposes of article. It is hereby declared that a

serious shortage of safe and sanitary nursing home accommodations for persons of low income, whose need for combined nursing care, lodging and board cannot readily be provided by the ordinary unaided operations of private enterprise, exists in many communities throughout the state; that there is need for non-profit corporations to construct, acquire, reconstruct, rehabilitate and improve, with loan participation by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, low cost nursing home accommodations, including such other facilities as may be incidental and appurtenant thereto, to meet such needs in furtherance of articles seventeen and eighteen of the constitution, and for public assistance to such companies by the granting of tax exemptions; that it is the policy of the state to promote the provision of such nursing home accommodations and that such provision is a public use and purpose.

§ 2852. Definitions. As used in this article the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context:

1. "Commissioner". The commissioner of health of the state of New York.

2. "Company." "Nursing home company." A non-profit nursing home company, duly incorporated pursuant to the provisions of the not-for-profit corporation law and this article, or a limited-profit nursing home company duly incorporated pursuant to the provisions of this article for the purpose of providing nursing home accommodations, including board and nursing care by or under the supervision of a duly licensed physician to sick, invalid, infirm, disabled or convalescent persons of low income or of providing health-related service as defined in article twenty-eight of this chapter to persons of low income, or any combination of the foregoing, and in addition thereto, of providing nursing care and health-related service, or either of them, to persons of low income who are not occupants of the project, and such other facilities as may be deemed by the commissioner to be incidental and appurtenant thereto.

3. "Project." "Nursing home project." A specific work or improvement, including lands, buildings, improvements, fixtures and articles of personal property, acquired, constructed, rehabilitated, managed, owned or operated by a company pursuant to this article to provide nursing home accommodations, including board and nursing care by or under the supervision of a duly licensed physician to sick, invalid, infirm, disabled or convalescent persons of low income or of providing health-related service as defined in article twenty-eight of this chapter to persons of low income, or any combination of the foregoing, or such care or service and hospital service, and in addition thereto of providing nursing care and health-related service, or either of them, or such care and service and hospital service, to persons of low income who are not occupants of the project, and such other facilities as may be deemed by the commissioner to be incidental and appurtenant thereto.

4. "Project cost". "Nursing home project cost". The sum total of all costs incurred by a company as approved by the commissioner as reasonable and necessary for carrying out all works and undertakings and providing all necessary equipment for the development of a project less any portion of any state, federal or municipal assistance grant as the commissioner shall, prior to the making of a loan by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, to a company, determine to be available to reimburse the company for the payment of such project costs prior to the initial occupancy of the project. These shall include but are not necessarily limited to the carrying charges during construction or rehabilitation up to and including the occupancy date, working capital not exceeding three per centum of the estimated total cost or three per centum of the actual total final cost, whichever is larger, the cost of all necessary studies, surveys, plans and specifications, architectural, engineering, legal or other special services, the cost of acquisition of land and any buildings and improvements thereon, site preparation and development, construction, reconstruction and equipment, including fixtures, equipment, and articles of personal property required for the operation of lodging, board, medical and nursing treatment facilities, the reasonable cost of financing incurred by the

company in the course of the development of the project, up to and including the occupancy date, the fees imposed by the commissioner and by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be; other fees charged, and necessary expenses incurred in connection with the initial occupancy of the project, and the cost of such other items as the commissioner may determine to be reasonable and necessary for the development of a project, less any and all rents and other net revenues from the operation of the real property, improvements or personal property on the project site, or any part thereof, by the company on and after the date on which the contract between the company and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, was entered into and prior to the occupancy date.

5. "Occupancy date". The date defined in the document providing for a loan between a company and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be.

6. "Loan". As used in this article, a loan shall mean either a mortgage loan or a project loan, each as defined in the New York state medical care facilities finance agency act, made by the agency to a nursing home company, as defined in the New York state medical care facilities finance agency act.

§ 2853. Nursing home companies; how created. 1. Notwithstanding the provisions of any other law or requirement to the contrary, non-profit nursing home companies shall be incorporated and organized pursuant to the not-for-profit corporation law and this article.

In addition to those matters required to be set forth in the certificate of incorporation by the not-for-profit corporation law, the certificate shall state:

a. That, among the purposes for which it is formed, the company is to

plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate one or more nursing home projects pursuant to this article.

b. The number of directors, which shall be not less than three nor more than thirty-five. One additional director may be designated by the commissioner. In the absence of fraud or bad faith, the director appointed by the commissioner shall not be personally liable for the debts, obligations or liabilities of the company.

c. That the real property of the company shall not be sold, transferred, encumbered or assigned except as permitted by the provisions of this article.

d. That the company has been organized exclusively to serve a public purpose and that it shall be and remain subject to the supervision and control of the commissioner pursuant to the provisions of article twenty-eight of this chapter and this article.

e. That all income and earnings of the company shall be used exclusively for its corporate purposes.

f. That no part of the net income or net earnings of the company shall inure to the benefit or profit of any private individual, firm or corporation.

2. Notwithstanding the provisions of any other law or requirement to the contrary, limited-profit nursing home companies shall be incorporated and organized pursuant to this article.

A limited-profit nursing home company may be created by three or more persons, approved by the commissioner, by making, subscribing, acknowledging and filing with the secretary of state a certificate which shall state, in addition to those matters required to be set forth in such certificate by the business corporation law to the extent that such law is not inconsistent with this article:

a. That among the purposes for which it is formed, the company is to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate one or more nursing home projects pursuant to this article.

b. The number of directors, which shall not be less than three nor more than thirty-five and who shall be elected by the shareholders of the company. One additional director, who shall not be a shareholder and who need not meet other qualifications which may be prescribed by the certificate of incorporation or the by-laws, may be designated by the commissioner. In the absence of fraud or bad faith, the director appointed by the commissioner shall not be personally liable for the debts, obligations or liabilities of the company.

c. That the real property of the company shall not be sold, transferred, encumbered or assigned except as permitted by the provisions of this article.

d. That the company has been organized to serve a public purpose and that it shall be and remain subject to the supervision and control of the commissioner pursuant to the provisions of article twenty-eight of this chapter and this article; that so long as this article remains applicable to any project of the company, all real and personal property acquired by it, and all structures erected or rehabilitated by it, shall be deemed to be acquired, rehabilitated or created for the proper effectuation of the purposes of this article, and that the directors and shareholders or debenture holders of such company shall be deemed to have agreed that they shall at no time receive or accept from such company in repayment of their investment in its shares or debentures any sums in excess of the par value of the share or debentures, together with such dividends, interest or other compensation as are prescribed by or permitted under this article, and that, upon dissolution of the company, any surplus remaining after the payment of all its obligations shall be distributed and disposed of and title to the property may be conveyed in fee, only as prescribed by this article.

e. That the entire amount to be paid in cash or property by the

shareholders and debenture holders shall be at least five percentum of the project cost.

f. That in the event of a violation by a company of any provision of the certificate of incorporation or of law or of the loan or mortgage contract or any order of the commissioner or of any rules and regulations duly promulgated pursuant to the provisions of this chapter, the commissioner may remove any or all of the existing directors of the company and appoint such person or persons whom the commissioner deems advisable, including officers and employees of the department, as new directors to serve in the places of those removed; that directors so appointed by the commissioner who are officers or employees of the department shall serve in such capacity without compensation; and that any directors so appointed by the commissioner shall serve only for a period coexistent with the duration of such violation or until the commissioner is assured in a manner satisfactory to him against violations of a similar nature.

The provisions of section thirty-five-a of the social services law shall not be applicable to a limited-profit nursing home company, notwithstanding any contrary provisions contained therein.

§ 2854. Consent of commissioner. Whenever any such certificate shall be presented to the secretary of state, he shall not file such certificate unless there shall accompany the same a certificate of the commissioner that he consents to the filing of such certificate; nor shall any amendment to the certificate of incorporation be filed unless it is accompanied by a certificate of the commissioner consenting thereto.

§ 2855. Prerequisites to consent of commissioner. The commissioner shall not approve any such certificate or amendment thereto unless and until there is endorsed thereon or annexed thereto the written approval of the public health council in accordance with section two thousand eight hundred one-a of the public health law.

§ 2856. Powers and limitations of a nursing home company. 1. Except as is inconsistent with the provisions of this article, a nursing home company shall have, in carrying out the purpose of this article, the powers conferred on corporations by the not-for-profit corporation law or the business corporation law, as the case may be, and shall be subject to the limitations contained therein.

2. Nursing home companies shall have the following additional powers:

(a) To make and execute contracts and other instruments necessary or convenient in the exercise of its powers.

(b) To acquire or contract to acquire from any persons, firm, corporation, public corporation, municipality, federal or state agency, by grant, purchase, or otherwise, leaseholds, real, personal or mixed property or any interest therein, and to sell, assign, exchange, transfer, mortgage or encumber the same.

(c) To own, hold, clear and improve, leasehold, real, personal or mixed property or any interest therein.

(d) In the case of a non-profit nursing home company, to issue non-interest bearing income debentures up to an amount representing the difference, if any, between the amount of the mortgage made by the company and the total estimated project cost, or the total actual cost, whichever is less; in the case of a limited-profit nursing home company, to issue shares and debentures only in such amounts and form and to such person, firm or corporation as may be approved by the commissioner.

(e) To construct, reconstruct, rehabilitate, improve, alter, repair, lease, manage or operate and otherwise provide nursing home projects.

(f) To insure or provide for the insurance of its property or operations as required by law and also against such other risks as it may deem advisable.

(g) To limit by contract the exercise of any of its powers.

(h) To invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement in property or securities in which savings banks may legally invest funds subject to their control.

(i) To sue and be sued.

(j) To have a seal and alter the same at pleasure.

(k) To make and from time to time amend and repeal bylaws, rules and regulations not inconsistent with the provisions of this article.

(l) To enter into contracts with the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, for loans, and to pay all such fees and charges as may be imposed by such agency as a condition of any such loan.

(m) To receive assistance from the state, federal government, municipalities or any person, firm or corporation by contract or otherwise; and to comply, subject to the provisions of this article, with the terms and conditions of such assistance, and in connection with assistance grants which are made by the state, federal government or a municipality to reimburse the company for project costs which have been paid for by such company from the proceeds of a loan or such other funds which are legally made available to the company, to hold and apply such assistance grants in accordance with the requirements of the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be.

(n) To do all other things necessary or convenient to carry out its powers.

3. No nursing home company shall:

(a) Acquire any real property or interest therein unless such company shall first have obtained from the commissioner a certificate that such acquisition is consistent with the purposes of this article.

(b) Issue notes, bonds, debentures, or other obligations without the approval of the commissioner. In the case of a limited-profit nursing home company, pay dividends on its shares and interest on its debentures at a rate higher than six per centum per annum, issue shares and debentures other than for money actually received for the use and lawful purposes of the company, except that shares and debentures may be issued for property actually received for the use and lawful purposes of the company upon a valuation approved by the commissioner and such valuation shall be used in computing the estimated or actual project cost.

(c) Without first having obtained the written consent of the commissioner:

(i) Construct, reconstruct, rehabilitate, improve, alter or repair any

project, or enter into any contract for such purposes.

(ii) Sell, transfer, lease or encumber any real property, except that no such consent shall be necessary in any sale in foreclosure pursuant to section two thousand eight hundred sixty-four.

(iii) Enter into any contracts relating to the management or operation of nursing home projects.

(iv) Enter into any contracts for the payment of any salary, fee or emolument to officers or employees.

(v) Make a guaranty of payment, or pledge any or all of its assets, income or revenues to secure payment of its obligations.

(vi) Voluntarily dissolve after twenty years, or such earlier date as the bonds issued by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, with respect to the project are subject to redemption; provided, however, that in the event an unpaid balance remains due on a loan from the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, the consent of the agency must also be obtained.

§ 2857. Members, officers and directors. 1. No member or director of a company shall receive any salary or other compensation for services as such member or director, other than reimbursement of actual and necessary expenses incurred in the performance of his duties. No member, officer, or employee of a company shall acquire any interest, direct or indirect, in any property then or thereafter included or planned to be included in a project, nor retain any interest, direct or indirect in any property acquired subsequent to his appointment or employment which is later included or planned to be included in a project. If any member, officer or employee of any company owns or controls an interest, direct or indirect, in any property included in a project, which was acquired prior to his appointment or employment, he shall disclose such interest and the date of acquisition thereof in writing to the company and such disclosure shall be entered upon the minutes of the company.

§ 2858. Loans. 1. Any nursing home company formed under this article

may, subject to the approval of the commissioner, borrow funds from the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, and the repayment thereof may be secured by bond or note and mortgage or other agreement which shall contain such terms and conditions as may be deemed necessary or desirable by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, or required by any agreement between the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, and the holders of its notes and bonds with respect to nursing home companies, including the right to assignment of rates and charges and entry into possession in case of default, but the operation of such project, in the event of such entry, shall be subject to regulations promulgated by the commissioner.

2. The New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, may make a contract to make loans to non-profit nursing home companies not to exceed the total project cost and to limited-profit nursing home companies not to exceed ninety-five per centum of the total project cost. Any loan which constitutes a mortgage loan as defined in the New York state medical care facilities finance agency act shall be secured by a first mortgage lien upon all the real property and improvements of which the project consists and upon all fixtures and articles of personal property attached to or used in connection with the operation of the project. Notwithstanding the foregoing provisions of this subdivision or any other provision of this article to the contrary, any personal property may be excluded from the lien of the mortgage securing such a mortgage loan provided (a) the commissioner finds that such property is not essential for the nursing home project as such term is defined in this article, and (b) the New York State housing finance agency or the New York state medical care facilities finance agency, as the case may be, consents to such exclusion.

3. Any inconsistent provision of law to the contrary notwithstanding, mortgages of a nursing home company shall be exempt from the mortgage recording taxes imposed by article eleven of the tax law.

§ 2859. Conditions and security for loans. No loan shall be made by the New York state housing finance agency or the New York state medical care facilities finance agency to a company until the commissioner has approved the project and finds that:

(1) The company has complied with all of the provisions of article twenty-eight of this chapter and this article;

(2) The plans and specifications conform to the requirements of all laws and regulations applicable thereto and assure adequate light, air, sanitation and fire protection and are satisfactory to him;

(3) The estimated revenue of the project will be sufficient to cover all probable costs of operation and maintenance, of fixed charges and such reserves as may be authorized by the commissioner or required by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be;

(4) Provision has been made for the purpose of providing for the payment of the difference, if any, between the estimated project cost and the loan; and in the event the final project cost shall exceed the estimated project cost, the difference between such final project cost and the loan;

(5) Provision has been made for the filing by the company with the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, of such financial statements including an annual report setting forth such information as the commissioner may require; and

(6) Provision has been made for the examination by the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, of the books and records of the company.

§ 2860. Rental rates and selection of occupants. 1. A company shall, with the approval of the commissioner, fix maximum rates to be charged occupants of each nursing home project for the facilities and services provided by the company to such occupants and the maximum rates to be charged to persons of low income who are not occupants of the project

for the nursing care and health-related service, or either of them, provided by the company to such persons, the average of such rates for any one project not to exceed the maximum average rates determined by the commissioner before any commitments are made by the company for the construction of the project. The commissioner upon his own motion, or upon application by the company or lienholder may vary the amount of such charge from time to time so as to secure, together with all other income of the company, sufficient income to meet, within reasonable limits, all necessary payments by the said company of all expenses, including fixed charges, sinking funds and reserves.

2. The facilities and services provided by the company to occupants shall be available for persons of low income, whose probable aggregate annual income at the time of admission and during the period of occupancy does not exceed two times the annual charges to be paid by such persons. Nursing care and health-related service, or either of them, shall be available to persons of low income who are not occupants of the project whose probable annual income does not exceed two times the average annual charge made to occupants of the project. The commissioner may make rules and regulations relating to the allocation of the income of a family among the members thereof for the purpose of determining the income attributable to any one person for the purpose of this subdivision.

§ 2861. Transfer of real property. Notwithstanding any requirement of law to the contrary or any provision of any general, special or local law, charter or ordinance, every executor, administrator, trustee, guardian or other person holding trust funds or acting in a fiduciary capacity, unless the instrument under which such fiduciary is acting expressly forbids, and the state, its subdivisions, municipalities, all other public bodies, all public officers, persons, partnerships and corporations owning or holding any real property, may grant, sell, lease or otherwise transfer any such real property or interest therein to a nursing home company and receive and hold any cash, exchanged therefor by such company and may execute such instruments and do such acts as may be deemed necessary or desirable by them or it and by the company in

connection with a project or projects and such sale, lease or transfer may be made without public auction or bidding; provided, however, that where such real property is within an urban renewal area, the disposition thereof shall be in accordance with the provisions of paragraph (d) of subdivision two of section five hundred seven of the general municipal law.

§ 2862. Supervision and regulation. 1. The commissioner may from time to time make, alter, amend and repeal rules and regulations for the supervision, examination, regulation and audit of nursing home companies and for carrying into effect the provisions and purposes of this article, and each company shall submit an annual report of its operations to the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, who may examine and audit the books and records of the company at any time.

2. The commissioner and the department of health shall have power to act for and in behalf of the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, in servicing the nursing home mortgage loans of such agency, and to perform such functions and services in connection with the making, servicing and collection of such loans as shall be requested by such agency.

3. (a) The commissioner and the department may, with respect to any nursing home project of which the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, has acquired the fee or otherwise, enter into an agreement with said agency subject to the approval of the director of the budget, for the department, as provided in paragraph (b) of this subdivision, to operate the said project in a manner consistent with the purposes of this article. In such event, the commissioner, on behalf of the department, shall have the power to use any available funds to pay all operating expenses and to comply with all the terms and provisions of the mortgage, if any, as though the mortgage had not been foreclosed, or

any other applicable agreement and to comply with the provisions of this article.

(b) Subject to the provisions of the agreement with said agency, the commissioner may contract with any person, firm or corporation which he deems qualified to operate and manage such project and to perform such duties and functions as he may deem necessary.

4. Whenever the commissioner shall be of the opinion that a company is failing or omitting, or is about to fail or omit to do anything required of it by law or by order of the commissioner and is doing or is about to do anything, or permitting anything, or is about to permit anything to be done, contrary to or in violation of law or of any order of the commissioner, or which is improvident or prejudicial to the interest of the public, the lienholders, the shareholders, or the occupants, the commissioner may, in addition to such other remedies as may be available, commence an action or proceeding in the supreme court of the state of New York in the name of the commissioner, for the purpose of having such violations or threatened violations stopped and prevented, and in such action or proceeding, the court may appoint a temporary or permanent receiver or both. Such action or proceeding shall be commenced by a petition to the supreme court, alleging the violation complained of and praying for appropriate relief. It shall thereupon be the duty of the court to specify the time, not exceeding twenty days after service of a copy of the petition, within which the company complained of must answer the petition. In case of any default or after answer the court shall immediately inquire into the facts and circumstances in such manner as the court shall direct in the interest of substantial justice without other or formal pleading. Such other persons or corporations as it shall seem to the court necessary or proper to join as parties in order to make its order or judgment effective, may be joined as parties. The final judgment in any such action or proceeding shall either dismiss the action or proceeding or direct that an order or an injunction, or both, issue, or provide for the appointment of a receiver as prayed for in the petition, or grant such other relief as the court may deem appropriate.

§ 2863. Payment out of earnings of limited-profit nursing home companies. There shall be paid annually out of the earnings of the limited-profit nursing home company, after providing for all taxes, assessments and expenses, a sum for interest on an amortization of the mortgage indebtedness of all mortgages of the company, depreciation charges and reserves if, when and to the extent deemed necessary by the commissioner, plus a dividend of six per centum on outstanding shares and interest not exceeding six per centum on the outstanding debentures of the company; the obligation in respect to such payments shall be cumulative, and any deficiency in interest, amortization, depreciation, reserves, if any, and dividends in any year shall be paid either from any cash surplus derived from earnings remaining in the treasury of such company in excess of the amount necessary to provide such cumulative annual sums or from the first available earnings in subsequent years. If, at the end of any three year period, the gross receipts should exceed the payments or charges necessary for the purposes of the project or projects and are not needed for a sinking fund, reserves or other purposes, the balance may be paid in further reduction of any indebtedness to the extent and upon terms and conditions approved by the commissioner. A sinking fund may be authorized by the commissioner to purchase and retire debentures or shares of the company at a price approved by the commissioner not exceeding par value thereof with accrued or unpaid dividends or interest or, if it is not practical to purchase such shares or debentures at a price so approved, the money in such sinking fund may be added to the surplus of such company. Any shares or debentures purchased out of such sinking fund shall be cancelled and shall not be reissued.

§ 2864. Tax exemptions of limited-profit nursing home companies. The real property in a project of a limited-profit nursing home company shall be exempt from all local and municipal taxes, other than assessments for local improvements, to the extent of the value of the property included in any such project as represents an increase over the assessed valuation of the real property, both land and improvements, acquired for the project on the date of its acquisition by the limited-profit nursing home company. The tax exemption shall operate and

continue so long as the mortgage loan by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, to the limited-profit nursing home company is outstanding but in no event for a period of more than thirty years, commencing in each instance from the date when the limited-profit nursing home company first acquired such property. If a project qualifying for a tax exemption pursuant to this section is sold, with the approval of the commissioner, to another limited-profit nursing home company, such successor company shall be entitled to all the benefits granted by this section. In the event that such sale is to a non-profit nursing home company, such successor company shall be entitled to all the benefits provided by section four hundred twenty-two of the real property tax law. Local and municipal taxes, for the purposes of this section, shall mean taxes levied by a county, city, village, town, school and special district but shall not include assessments for local improvements.

§ 2865. Voluntary dissolution. 1. At any time after the expiration of twenty years after the occupancy date, or such earlier date as the bonds issued by the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, with respect to the project are subject to redemption, a company may be voluntarily dissolved, with the consent of the commissioner, upon repayment in full of all obligations under the mortgage and payment of all obligations of the company, as approved by the commissioner.

2. Upon such dissolution, title of the project of a limited-profit nursing home company may be conveyed in fee to the owner or owners of its shares or to any other entity authorized by law designated by it or them for the purpose, provided, however, that prior to any such dissolution and conveyance, payment shall be made of all current operating expenses, taxes, indebtedness and all accrued interest thereon and the par value of and accrued dividends on the outstanding shares of such company, if any. After such dissolution and conveyance, or such reconstitution, the provisions of this article shall become and be inapplicable to any such project and any tax exemption granted with

respect to such project pursuant to this article shall cease and terminate.

§ 2866. Foreclosures and judgments. 1. In any foreclosure action the commissioner shall be made a party defendant. He shall take all steps necessary to protect the interests of the public therein and no costs shall be awarded against him. Foreclosures shall not be decreed unless the court to which application is made shall be satisfied that the interests of the lienholder or holders cannot be adequately assured except by the sale of the property. In any such proceeding, the court shall be authorized to appoint the commissioner as receiver of the property, or to grant such other and further relief as may be reasonable and proper.

2. Notwithstanding the foregoing provisions of this section, wherever it shall appear that the New York state housing finance agency or the New York state medical care facilities finance agency shall have loaned on a mortgage which is a lien upon any such property, such New York state housing finance agency or New York state medical care facilities finance agency, as the case may be, shall have all the remedies available to a mortgagee under the laws of the state of New York, free from any restrictions contained in this section, except that the commissioner shall be made a party defendant and that the commissioner shall take all steps necessary to protect the interests of the public and no costs shall be awarded against him.

3. In the event of a judgment against a company in any action not pertaining to the collection of a mortgage indebtedness, there shall be no sale of any of the real property of such company except upon sixty days' written notice to the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be. Upon receipt of such notice the commissioner and the agency shall take such steps as in its judgment may be necessary to protect the rights of all parties.

§ 2868. Fees and charges. The commissioner may by regulation establish and charge to any nursing home company, for the period of occupancy date to mortgage discharge, a fee for inspection, regulation, supervision and audit not to annually exceed two-tenths of one percent of the mortgage loan to recover the departmental costs in performing these functions in relation to any nursing home project financed or refinanced by a loan made under this article prior to April first, two thousand fourteen. Notwithstanding the foregoing, no such fee shall be charged or payable pursuant to this section with respect to a nursing home project financed or refinanced with bonds issued on or after April first, two thousand fourteen.

§ 2869. Separability. If any clause, sentence, paragraph or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

ARTICLE 28-B

HOSPITAL MORTGAGE LOAN CONSTRUCTION

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hospital mortgages.

§ 2870. Short title. This article shall be known, and may be cited and referred to as the "hospital loan construction law".

§ 2871. Policy and purposes of article. Many hospitals and other health facilities throughout the state are becoming obsolete and are no longer adequate to meet the needs of modern medicine. As a result of rapid technological changes, such facilities require substantial structural or functional changes. Others are unsuited for continued use by virtue of their location and the physical characteristics of their existing plants and should be replaced. Such inadequate and outmoded facilities deny to the people of the state the benefits of health care of the highest quality, efficiently and promptly provided at a reasonable cost. Their replacement and modernization is essential to protect and prolong the lives of the state's population and cannot readily be accomplished by the ordinary unaided operation of private enterprise.

It is the purpose of this article to encourage the timely construction and modernization, including the equipment, of hospital and other health facilities, which are necessary for the diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, and of facilities incidental or appurtenant thereto, with mortgage loan participation by the New York state housing finance agency, all in furtherance of article seventeen of the constitution. It is hereby declared to be the policy of the state to encourage the provision of modern, well-equipped health facilities, and such provision is hereby declared to be a public use and purpose.

§ 2872. Definitions. As used in this article, the following words and phrases shall have the following meanings unless a different meaning is plainly required by the context:

1. "Commissioner". The commissioner of health of the state of New York.

2. "Agency". The New York state housing finance agency created by article three of the private housing finance law or the New York state medical care facilities finance agency created by the New York state medical care facilities finance agency act.

3. "Eligible borrower". "Hospital corporation". A non-profit hospital corporation organized under the laws of this state, or a non-profit medical corporation organized under and governed by article forty-four of this chapter, which has entered into a regulatory agreement in accordance with the provisions of section twenty-eight hundred seventy-three of this article.

3-a. "Secured hospital project bonds" shall mean outstanding bonds issued on behalf of a not-for-profit hospital corporation organized under the laws of this state, which hospital has previously been designated by the commissioner and the public health council to be eligible to receive distributions from the reimbursement pools established pursuant to paragraph (c) of subdivision nine of section twenty-eight hundred seven-a of this chapter, or any successor pool or pools established to serve a substantially similar purpose to such pools.

4. "Project". "Hospital project". A specific work or improvement, including lands, buildings, improvements, fixtures and articles of personal property, acquired, constructed, rehabilitated, owned and operated by an eligible borrower pursuant to this article, to provide hospital or other facilities for the prevention, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, and for facilities incidental or appurtenant thereto. "Project" and "Hospital project" shall also mean the refinancing of existing indebtedness which constitutes a lien or other encumbrance upon the real property or assets of the eligible borrower whether or not such refinancing is related to the construction, acquisition or rehabilitation of a specific work or improvement. The term "project" or

"hospital project" as used in this subdivision shall also mean a separate work or improvement, including lands, buildings, fixtures and personal property related thereto owned and operated by an eligible borrower to provide such services, functions, capabilities and facilities as may be convenient or desirable for the operation of a hospital or other such facility.

5. "Project cost". "Hospital project cost". The sum total of all costs incurred by an eligible borrower as approved by the commissioner as reasonable and necessary for carrying out all works and undertakings and providing all necessary equipment for the development of a project less any portion of any state, federal or municipal assistance grant as the commissioner shall, prior to the making of a loan by the agency to an eligible borrower, determine to be available to reimburse the eligible borrower for the payment of such project costs prior to the initial occupancy of the project. These shall include but are not necessarily limited to the carrying charges during construction or rehabilitation up to and including the occupancy date, working capital not exceeding three per centum of the estimated total cost or three per centum, of the actual total final cost, whichever is larger, the cost of all necessary studies, surveys, plans and specifications, architectural, engineering, legal or other special services, the cost of acquisition of land and any buildings and improvements thereon, site preparation and development, construction, reconstruction and equipment, including fixtures, equipment, and articles of personal property required, the reasonable cost of financing incurred by an eligible borrower in the course of the development of the project, up to and including the occupancy date, the fees imposed by the commissioner and by the agency; other fees charged, and necessary expenses incurred in connection with the initial occupancy of the project, and the cost of such other items as the commissioner may determine to be reasonable and necessary for the development of a project, less any and all rents and other net revenues from the operation of the real property, improvements or personal property on the project site, or any part thereof, by an eligible borrower on and after the date on which the contract between an eligible borrower and the agency was entered into and prior to the occupancy date. The definition contained in this subdivision shall also include all costs relating to

the refinancing of existing indebtedness which constitutes a lien or other encumbrance upon the real property or assets of the eligible borrower provided that the amount of the indebtedness to be so refinanced has been found by the commissioner to be reasonable.

6. "Occupancy date". The date defined in the document providing for a loan between an eligible borrower and the agency.

7. "Loan". As used in this article, a loan shall mean either a mortgage loan or a project loan, each as defined in the New York state medical facilities finance agency act, made by the agency to an eligible borrower, as defined in the New York state medical facilities finance agency act.

§ 2873. Regulation of eligible borrowers. 1. Every eligible borrower, as a condition precedent to borrowing funds from the agency, shall enter into a regulatory agreement with the commissioner which shall provide:

(a) that the real property or other assets mortgaged or otherwise pledged to the agency shall not be sold, leased, transferred, encumbered or assigned without the prior consent of the commissioner until the eligible borrower shall have repaid in full all obligations due to the agency and has paid such other obligations as may be required by the commissioner provided, however, the provisions of this paragraph shall not apply to any actions taken pursuant to section twenty-eight hundred seventy-nine of this article;

(b) that the eligible borrower will maintain books and records and a system of accounts satisfactory to the commissioner and the agency including but not limited to separate books, records and accounts for (i) all monies advanced to the eligible borrower by the agency or from any other source or sources, public or private, for the construction, reconstruction, rehabilitation, improvement or equipment of the project and (ii) all monies repaid in satisfaction of any indebtedness to the agency or other indebtedness as required by the commissioner; and the eligible borrower agrees that all of its books, records and accounts shall be open to examination by the commissioner and the agency at any time;

(c) that the eligible borrower shall file with the commissioner and the agency such financial statements including an annual report setting forth such information as the commissioner may require;

(d) that the eligible borrower shall not acquire any real property or interest therein for the purpose of constructing, reconstructing, rehabilitating or improving a hospital project without first having obtained from the commissioner a certificate that such acquisition is consistent with the purposes of this article;

(e) that the eligible borrower shall not issue notes, bonds, debentures or other obligations other than for money or property actually received for the use and lawful purposes of the eligible borrower and no such note, bond, debenture or other obligation shall constitute a lien or encumbrance against the project, or any real property or other asset mortgaged or otherwise pledged to the agency, provided, however, that a hospital constituting an eligible borrower may incur, assume or guarantee indebtedness from a lender other than the New York state medical care facilities finance agency or incur or assume indebtedness from the New York state medical care facilities finance agency under a separate bond resolution pursuant to the provisions of section five-c of the New York state medical care facilities finance agency act;

(f) that the eligible borrower shall not without first having obtained the written consent of the commissioner:

(i) construct, reconstruct, rehabilitate, improve, alter or repair the project or enter into a contract therefor;

(ii) enter into contracts relating to the management or operation of the project;

(iii) make a guaranty of payment out of monies pledged to the agency or pledge any or all of its assets, income or revenue pledged to the agency to secure payment of its obligations;

(iv) voluntarily dissolve;

(g) that no member, officer or employee of the corporation which is an eligible borrower shall acquire any interest, direct or indirect, in any property then or thereafter included or planned to be included in a project, nor retain any interest direct or indirect in any property acquired subsequent to his appointment or employment which is later included or planned to be included in a project. If any member, officer

or employee of a corporation which is an eligible borrower owns or controls an interest, direct or indirect, in any property included in a project which was acquired prior to his appointment or employment, he shall disclose such interest and the date of acquisition to the corporation and such disclosure shall be entered upon the minutes of such corporation and a copy of such minutes shall be forwarded to the commissioner;

(h) that all income and earnings of the eligible borrower shall be used exclusively for its corporate purposes;

(i) that no part of the net income or earnings of the corporation shall inure to the benefit or profit of any private individual, firm or corporation;

(j) such other matters as the commissioner or the agency may require.

2. This regulatory agreement shall terminate at any time after the expiration of twenty years after the occupancy date, or such earlier date as the bonds issued by the agency with respect to the hospital project are subject to redemption, upon the consent of the commissioner and upon the repayment in full of all obligations due to the agency and of such other obligations as the commissioner may require.

§ 2874. Loans. 1. Any eligible borrower may, subject to the approval of the commissioner, borrow funds from the agency and the repayment thereof may be secured by bond or note and mortgage or other agreement which shall contain such terms and conditions as may be deemed necessary or desirable by the agency or required by any agreement between the agency and the holders of its notes and bonds, including the right to assignment of rates and charges and entry into possession in case of default, but the operation of such project, in the event of such entry, shall be subject to regulations promulgated by the commissioner.

2. The agency may make contracts to make loans to an eligible borrower in an amount not to exceed the total project cost. Any such loan which constitutes a mortgage loan as defined in the New York state medical care facilities finance agency act shall be secured by a first mortgage lien upon all the real property and improvements of which the project

consists and upon all personal property attached to or used in connection with the operation of the project. In the case of a mortgage loan in an amount greater than ninety per centum of the total project cost, the commissioner may, in his discretion, require satisfactory independent guarantees that the loan will be repaid according to the terms of the bond or note and mortgage of the eligible borrower. Any mortgage loan may be further secured by such a lien upon other real property owned by the eligible borrower. Notwithstanding the foregoing provisions of this subdivision or any other provision of this article to the contrary, any personal property may be excluded from the lien of the mortgage securing such a mortgage loan, provided (a) the commissioner finds that such property is not essential for the rendition of required hospital services as such term is defined in article twenty-eight of this chapter, and (b) the agency consents to such exclusion.

3. In connection with assistance grants which are made by the state, federal government or a municipality to reimburse the eligible borrower for project costs which have been paid for by such eligible borrower from the proceeds of a loan or such other funds which are legally made available to the eligible borrower, the eligible borrower shall hold and apply such assistance grants in accordance with the requirements of the commissioner and the agency.

4. Any inconsistent provision of law to the contrary notwithstanding, mortgages of an eligible borrower shall be exempt from the mortgage recording taxes imposed by article eleven of the tax law.

5. The dormitory authority of the state of New York and the New York state urban development corporation are each hereby authorized to issue bonds in one or more series pursuant to article 5-C or article 5-F of the state finance law for the purpose of refunding outstanding secured hospital project bonds, as defined in subdivision three-a of section twenty-eight hundred seventy-two of this article, and to finance one or more related debt service reserve funds and to pay costs of issuance attributable to such refunding bonds.

*** § 2874-a. Mortgage loans to eligible secured hospital borrowers.**

Except as specified herein, eligible secured hospital borrowers shall be subject to all of the requirements to which eligible borrowers are subject under this article. Mortgage loans to eligible secured hospital borrowers shall be subject to the following criteria:

1. The medical care facilities finance agency shall not make a mortgage loan to eligible secured hospital borrowers unless the commissioner has recommended the project based on public need, the hospital discloses the financial resources available to it, and the hospital complies with the provisions of article twenty-eight of this chapter. In considering the financial resources available to support a project, the commissioner shall take into account programs designed to offset eligible secured hospital borrowers' past and current unmet bad debt and charity care losses.

2. A mortgage loan to an eligible secured hospital borrower made by the medical care facilities finance agency shall not exceed an amount equal to one hundred percent of the total project costs, which costs shall include all costs associated with the refinancing of indebtedness attributable to unmet bad debt and charity care losses. To ensure the timely repayment of the principal and interest due on the indebtedness relating to such refinancings, the commissioner may authorize reimbursement to eligible secured hospital borrowers for capital related expenses including but not limited to depreciation, rentals and interest on capital debt and may advance the payment of depreciation to such borrowers as needed.

* NB Expired December 31, 2015

§ 2875. Conditions and security for loans. No loan shall be made by the agency to an eligible borrower until the commissioner has approved the project and finds that:

1. The eligible borrower has complied with all of the provisions of article twenty-eight of this chapter and this article;

2. The plans and specifications conform to the requirements of all laws and regulations applicable thereto and assure adequate light, air, sanitation and fire protection and are satisfactory to him;

3. The estimated revenue of the project or from other funds of the eligible borrower pledged, assigned or otherwise to be made available to the agency will be sufficient to cover all probable costs of operation and maintenance, of fixed charges and such reserves as may be authorized by the commissioner or required by the agency;

4. Provision has been made for the purpose of providing for the payment of the difference between the estimated project cost and the loan; and in the event the final project cost shall exceed the estimated project cost, the difference between such final project cost and the loan;

5. The eligible borrower has entered into a regulatory agreement pursuant to section twenty-eight hundred seventy-three of this article.

§ 2876. Occupancy or other rates. An eligible borrower shall, with the approval of the commissioner, fix rates to be charged for occupancy or other use of each project. The commissioner upon his own motion, or upon application by the eligible borrower or lienholder may vary the amount of such charge from time to time so as to secure, together with all other income of the eligible borrower pledged, assigned or otherwise made available to the agency, sufficient income to meet, within reasonable limits, all necessary payments by the said eligible borrower of all expenses, including fixed charges, sinking funds and reserves.

§ 2877. Transfer of real property. Notwithstanding any requirement of law to the contrary or any provision of any general, special or local law, charter or ordinance, every executor, administrator, trustee, guardian or other person holding trust funds or acting in a fiduciary capacity, unless the instrument under which such fiduciary is acting expressly forbids, and the state, its subdivisions, municipalities, all

other public bodies, all public officers, persons, partnerships and corporations owning or holding any real property, may grant, sell, lease or otherwise transfer any such real property or interest therein to an eligible borrower and receive and hold any cash, exchanged therefor by such an eligible borrower and may execute such instruments and do such acts as may be deemed necessary or desirable by them or it and by the eligible borrower in connection with a project or projects and such sale, lease or transfer may be made without public auction or bidding; provided, however, that where such real property is within an urban renewal area the disposition thereof shall be in accordance with the provisions of paragraph (d) of subdivision two of section five hundred seven of the general municipal law.

§ 2878. Supervision. 1. The commissioner may from time to time make, alter, amend and repeal rules and regulations for the supervision, examination, regulation and audit of an eligible borrower and for carrying into effect the provisions and purposes of this article, and each eligible borrower shall submit an annual report of its operations to the commissioner and the agency who may examine and audit the books and records of the eligible borrower at any time.

2. The commissioner and the department of health shall have power to act for and in behalf of the agency in servicing the hospital loans of the agency, and to perform such functions and services in connection with the making, servicing and collection of such loans as shall be requested by the agency.

3. (a) The commissioner and the department may, with respect to any hospital project of which the agency has acquired the fee or otherwise, enter into an agreement with said agency subject to the approval of the director of the budget, for the department, as provided in paragraph (b) of this subdivision, to operate the said project in a manner consistent with the purposes of this article. In such event, the commissioner, on behalf of the department, shall have the power to use any available funds to pay all operating expenses and to comply with all the terms and provisions of the mortgage, if any, as though the mortgage had not been

foreclosed, or any other applicable agreement and to comply with the provisions of this article.

(b) Subject to the provisions of the agreement with said agency, the commissioner may contract with any person, firm or corporation which he deems qualified to operate and manage such project and to perform such duties and functions as he may deem necessary.

4. Whenever the commissioner shall be of the opinion that an eligible borrower is failing or omitting, or is about to fail or omit to do anything required of it by law or by order of the commissioner and is doing or is about to do anything, or permitting anything, or is about to permit anything to be done, contrary to or in violation of law or of any order of the commissioner, or which is improvident or prejudicial to the interest of the public, the lienholders, the shareholders, or the occupants, the commissioner may, in addition to such other remedies as may be available, commence an action or proceeding in the supreme court of the state of New York in the name of the commissioner, for the purpose of having such violations or threatened violations stopped and prevented, and in such action or proceeding, the court may appoint a temporary or permanent receiver or both. Such action or proceeding shall be commenced by a petition to the supreme court, alleging the violation complained of and praying for appropriate relief. It shall thereupon be the duty of the court to specify the time, not exceeding twenty days after service of a copy of the petition, within which the eligible borrowers complained of must answer the petition. In case of any default or after answer the court shall immediately inquire into the facts and circumstances in such manner as the court shall direct in the interest of substantial justice without other or formal pleading. Such other persons or corporations as it shall seem to the court necessary or proper to join as parties in order to make its order or judgment effective, may be joined as parties. The final judgment in any such action or proceeding shall either dismiss the action or proceeding or direct that an order or an injunction, or both, issue, or provide for the appointment of a receiver as prayed for in the petition, or grant such other relief as the court may deem appropriate.

§ 2879. Foreclosures and judgments. 1. In any foreclosure action the commissioner shall be made a party defendant. He shall take all steps necessary to protect the interests of the public therein and no costs shall be awarded against him. Foreclosures shall not be decreed unless the court to which application is made shall be satisfied that the interests of the lienholder or holders cannot be adequately assured except by the sale of the property. In any such proceeding, the court shall be authorized to appoint the commissioner as receiver of the property, or to grant such other and further relief as may be reasonable and proper.

2. Notwithstanding the foregoing provisions of this section, wherever it shall appear that the agency shall have loaned on a mortgage which is a lien upon any such property, such agency shall have all the remedies available to a mortgagee under the laws of the state of New York, free from any restrictions contained in this section, except that the commissioner shall be made a party defendant and that the commissioner shall take all steps necessary to protect the interests of the public and no costs shall be awarded against him.

3. In the event of a judgment against an eligible borrower in any action not pertaining to the collection of a mortgage indebtedness, there shall be no sale of any of the real property of such eligible borrower except upon sixty days' written notice to the commissioner and the agency. Upon receipt of such notice the commissioner and the agency shall take such steps as in its judgment may be necessary to protect the rights of all parties.

§ 2880. Hospital facilities development fund. 1. Establishment of fund. a. There is hereby created and established in the department of health a revolving fund to be known as the "hospital facilities development fund".

b. There shall be paid into such hospital facilities development fund (a) any monies appropriated and made available by the state for the purposes of such fund, (b) notwithstanding the provisions of the state

finance law or any other provision of law, any monies which the department of health shall receive in repayment of advances made from the fund, and (c) any other monies which may be made available to the department of health for the purposes of such fund from any other source or sources.

c. Any monies held in such hospital facilities development fund not required for immediate disbursement may be invested, at the discretion of the commissioner, in obligations of the state or the United States government or obligations the principal and interest of which are guaranteed by the state or the United States government. Any income or interest earned by, or increment to, such hospital facilities development fund shall be added to the monies held in such fund for the purpose herein provided.

2. Advances; conditions; prepayment. a. The commissioner is hereby authorized to use the monies held in the hospital facilities development fund to make non-interest bearing advances to eligible borrowers providing or arranging for health services in connection with a prepaid comprehensive health care plan. Such monies shall be paid out of such fund, after audit by and upon the warrant of the comptroller, on vouchers approved by the commissioner.

b. No such advances may be made unless the commissioner reasonably anticipates that a New York state housing finance agency mortgage or a New York state medical care facilities finance agency mortgage, as the case may be, will be obtained for the hospital project and makes a finding to such effect. Such finding shall be conclusive evidence of the facts therein contained except upon proof of fraud or willful misfeasance.

c. The proceeds of such advances shall be used only to defray the development costs of such project. The "development costs" means the costs approved by the commissioner as appropriate expenditures which may be incurred prior to the initial advance of the proceeds of a New York state housing finance agency mortgage or a New York state medical care facilities finance agency mortgage, as the case may be including but not

limited to: (a) payments for options to purchase properties for the proposed hospital project or for deposits on account of contracts to purchase such properties; (b) legal and organizational expenses, including payment of attorneys' fees, project manager, administrative and clerical staff salaries, office rent and other incidental expenses; (c) payment of fees and expenses for preliminary surveys, reports and feasibility studies, advances for planning, engineering and architectural work; and (d) such other expenses incurred by such eligible borrower as the commissioner may deem appropriate to effectuate the purposes of this article.

d. If such eligible borrower obtains a mortgage loan from the New York state housing finance agency or the New York state medical care facilities finance agency, each such advance shall be repaid in full by such eligible borrower to the department of health concurrently with receipt by the eligible borrower of the first proceeds of such loan.

e. If the commissioner in his discretion shall, at any time, determine that a New York state housing finance agency mortgage loan or a New York state medical care facilities finance agency mortgage loan may not be obtained, or that any advance made pursuant to this section is in jeopardy of not being repaid or that the proposed project for which such advance was made is in jeopardy of not being constructed, then and in any such event all advances made to such eligible borrower from the hospital facilities development fund shall be deemed due and payable by the eligible borrower upon the demand of the commissioner.

3. Examination by comptroller. The comptroller, or his legally authorized representative, is hereby authorized and empowered to examine the books and accounts of the department of health relating to the hospital facilities development fund, and from time to time, until the advances have been repaid to the hospital facilities development fund, to examine the books and accounts of each eligible borrower receiving such advances, including its receipts, disbursements, contracts, leases, loans, and any other monies relating to its financial operation.

§ 2881. Fees and charges. The commissioner may, by regulation, establish and charge to eligible borrowers, for the period from occupancy date to mortgage discharge, a fee for inspection, regulation, supervision and audit not to annually exceed two-tenths of one percent of the mortgage loan to recover the departmental costs in performing these functions in relation to any hospital project financed or refinanced by a loan made under this article prior to April first, two thousand fourteen. Notwithstanding the foregoing, no such fee shall be charged or payable pursuant to this section with respect to a hospital project financed or refinanced with bonds issued on or after April first, two thousand fourteen.

§ 2882. Separability. If any clause, sentence, paragraph or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

§ 2883. Authority and responsibility of commissioner regarding hospital mortgages. For the purposes of this article, only the provisions of sections twenty-eight hundred seventy, twenty-eight hundred seventy-one, twenty-eight hundred seventy-two, twenty-eight hundred seventy-three, twenty-eight hundred seventy-four, twenty-eight hundred seventy-five, twenty-eight hundred seventy-seven, subdivision one of section twenty-eight hundred seventy-eight, twenty-eight hundred eighty, twenty-eight hundred eighty-one and twenty-eight hundred eighty-two shall apply to loans made pursuant to this article after April first, nineteen hundred eighty-one.

ARTICLE 28-C

NURSE MANPOWER CENTER

Section 2890. Policy and purposes of article.

2891. Nurse manpower center.

2892. Commissioner; powers and duties.

§ 2890. Policy and purposes of article. It is hereby declared that the recruitment, training, availability and proper performance of nursing service personnel in hospitals, nursing homes and home health agencies are matters of vital concern to the public health. Shortages and improper utilization of nursing service resources result in neglect of the health needs of sick, injured, disabled, infirm and invalid persons, and improper performance of nursing services. In order to provide for the protection and promotion of the health of the inhabitants of the state, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to nursing service and the utilization of nursing service manpower resources by hospitals, nursing homes and home health agencies.

§ 2891. Nurse manpower center. The commissioner shall establish within the department a nurse manpower center for the purposes of instituting and conducting nurse manpower studies and surveys and the making of recommendations for the improvement of nursing service.

§ 2892. Commissioner; powers and duties. The commissioner shall have the following powers and duties:

(a) To conduct studies and surveys of nursing service to determine public nursing service needs and the extent to which such needs can be provided by homemakers, home health aides, licensed practical nurses and registered professional nurses.

(b) To make recommendations to nursing service organizations, hospitals, nursing homes and home health agencies relating to personnel practices, recruitment, training, conditions of employment and compensation for the purposes of improvement of the quality and availability of nursing service and making more effective use of existing nurse manpower.

(c) To advise the department of education as to the extent to which

hospitals, nursing homes and home health agencies are suitable as clinical facilities for the training of nursing service personnel.

(d) To institute and operate refresher training programs for nursing service personnel.

(e) To enlist in a nurse reserve those inactive nurses interested in returning to active nursing service.

(f) To maintain a central registry of nursing manpower resources including, but not limited to, data concerning registered professional nurses and licensed practical nurses.

(g) To institute and operate a nurse manpower recruitment service including, but not limited to, a guidance and counseling service.

ARTICLE 28-D

PRACTICE OF NURSING HOME ADMINISTRATION

Title	Section
I. General provisions and public policy	2895
II. Licensing and registration	2896
III. Violations; penalties	2897
IV. Construction	2898

TITLE I

GENERAL PROVISIONS AND PUBLIC POLICY

Section 2895. Declaration of policy and statement of purpose.

2895-a. Definitions.

2895-b. Nursing home staffing levels.

§ 2895. Declaration of policy and statement of purpose. It is hereby declared and found that the health and safety of the people of the state of New York require that the administration of medical facilities providing nursing home accommodations be adequate and proper, and that the quality of such administrative services is related to the calibre of training and experience of the persons administering such facilities. It is the purpose of this article to establish standards of education, training and experience and provide for the examination, licensure and

registration of nursing home administrators.

§ 2895-a. Definitions. As used in this article, the following words and phrases shall have the following meanings, unless the context otherwise plainly requires:

1. "Nursing home" means a facility issued an operating certificate as a nursing home pursuant to article twenty-eight of this chapter.

2. "Board" means the board of examiners of nursing home administrators as provided for in this article.

3. "Nursing home administrator" means an individual who is charged with and has responsibility for the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

§ 2895-b. Nursing home staffing levels. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Certified nurse aide" means any person included in the nursing home nurse aide registry pursuant to section twenty-eight hundred three-j of this chapter.

(b) "Licensed nurse" means a registered professional nurse or licensed practical nurse licensed pursuant to article one hundred thirty-nine of the education law.

(c) "Staffing hours" means the hours reported by a nursing home to the federal Centers for Medicare and Medicaid Services through the payroll based journal for long-term care facilities.

(d) "Nurse aides" means any person who is included in the nurse aide hour component of the payroll based journal for long-term care facilities but has not yet been certified as a certified nurse aide.

2. Staffing standards. (a) The commissioner shall, by regulation, establish staffing standards for nursing home minimum staffing levels to

meet applicable standards of service and care and to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident of the facility. Compliance shall be determined quarterly by comparing the daily average of the number of hours provided per resident, per day, using the federal Centers for Medicare and Medicaid Services payroll based journal and the facility's average daily census on a daily basis.

(b) The commissioner shall establish, by regulation, civil penalties for facilities out of compliance with minimum staffing levels. Such regulations shall include a range of penalties to account for mitigating factors which shall include:

(i) extraordinary circumstances facing the facility, including, but not limited to, whether the facility has suffered through a natural disaster or other catastrophic event, an officially declared national emergency, or state or municipal emergency declared pursuant to article two-B of the executive law, which has been initially declared subsequent to the effective date of this section, or other such conditions or unforeseen circumstances as determined by the commissioner;

(ii) the frequency and nature of non-compliance; and

(iii) the existence of an acute labor supply shortage within a particular region. When determining if there is an acute labor supply shortage within a specific region in a specific quarter, or a shorter period of time as determined by the commissioner, the commissioner shall take into consideration the following factors: regional labor supply of available certified nurse aides, licensed practical nurses and registered nurses; regional pay rates for the relevant titles as determined by the federal department of labor, bureau of labor statistics; and evidence that the facility attempted to procure sufficient staffing.

(c) At least thirty days before any action is taken by the commissioner under paragraph (b) of this subdivision, the commissioner shall post the assessed penalties, and any mitigating factors that were considered in assessing the penalty on the department's website.

(d) In determining whether a nursing home has violated its obligations under this section, it shall not be a defense that such nursing home was unable to secure sufficient staff if the lack of staffing was foreseeable and could be prudently planned for, or involved routine

staffing needs that arose due to typical staffing patterns, typical levels of absenteeism, or time off typically approved by the employer for vacation, holidays, sick leave, and personal leave.

(e) A civil penalty shall not be imposed under this section until after April first, two thousand twenty-two;

(f) Every nursing home shall:

(i) comply with the staffing standards under this section; and

(ii) employ sufficient staffing levels to meet applicable standards of service and care and to provide service and care and to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident of the facility.

(g) Staffing standards established under this subdivision shall, at a minimum, be the staffing standards established under subdivision three of this section.

(h) The minimum staffing standard includes the hours which are required to be reported by a nursing home to the federal Centers for Medicare and Medicaid Services through the payroll based journal for long-term care for certified nursing assistants and licensed nurses. In determining compliance with the staffing standards under this subdivision, an individual shall not be counted while performing administrative services as defined in the payroll based journal for long-term care facilities.

3. Statutory standard. (a) Beginning January first, two thousand twenty-two every nursing home shall maintain daily average staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, a licensed nurse or a nurse aide; provided that out of such 3.5 hours, no less than 2.2 hours of care per resident per day shall be provided by a certified nurse aide or a nurse aide, and no less than 1.1 hours of care per resident per day shall be provided by a licensed nurse.

(b) Beginning January first, two thousand twenty-three and thereafter every nursing home shall maintain daily average staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide or a licensed nurse; provided that out of such 3.5 hours, no less than 2.2 hours of care per resident per day shall be provided by a certified nurse aide, and no less than 1.1 hours of care per resident per day

shall be provided by a licensed nurse.

4. Public disclosure of staffing levels. (a) A nursing home shall post information regarding nurse staffing that the facility is required to make available to the public under section twenty-eight hundred five-t of this chapter. Information under this paragraph shall be displayed in a form approved by the department and be posted in a manner which is visible and accessible to residents, their families and the staff, as required by the commissioner.

(b) A nursing home shall post a summary of this section, provided by the department, in proximity to each posting required by paragraph (a) of this subdivision.

* 5. Fines and civil penalties. (a) All fines and civil penalties collected by the commissioner pursuant to this section shall be deposited into a nursing home worker recruitment and safety fund established pursuant to section ninety-nine-ss of the state finance law to enhance the quality of employment for residential health care facility employees and assist in the recruitment and safety of residential health care facility staff.

(b) The commissioner shall distribute monies made available for this purpose under this subdivision in the form of grants to providers. In determining the funding for providers, the commissioner shall consider criteria including, but not limited to, the overall census of a facility and the rate region the facility is located within. The commissioner shall promulgate the rules and regulations necessary for implementing the program.

* NB Effective December 19, 2026

TITLE II

LICENSING AND REGISTRATION

Section 2896. License and registration required.

2896-a. Board of examiners of nursing home administrators.

2896-b. Rules and regulations; powers and duties.

2896-c. Qualifications of applicants for licensure.

2896-d. Examination of applicants.

2896-e. Issuance of license.

2896-f. Temporary licenses.

2896-g. Registration.

2896-h. Reports.

§ 2896. License and registration required. On and after July first, nineteen hundred seventy, no person shall practice or represent himself as a nursing home administrator unless he is licensed by the board and registered by the department pursuant to the provisions of this article.

§ 2896-a. Board of examiners of nursing home administrators. 1. There shall be within the department a board of examiners of nursing home administrators consisting of thirteen members appointed by the commissioner, all of whom shall be citizens of the United States and residents of the state of New York. The board shall be composed of one physician, one hospital administrator, one professional registered nurse, three nursing home administrators employed in proprietary nursing homes and three nursing home administrators employed in voluntary nursing homes, each of whom shall have not less than five years' experience in the care of chronically ill or infirm aged patients. Three members shall be representative of the public and one member shall be appointed from a college providing training for nursing home administrators. A member's term shall expire upon a change of status. Each member appointed from a profession requiring licensure or registration to practice in the state shall be licensed or registered except for those nursing home administrators first appointed to the board who shall be required only to possess the qualifications and be eligible for licensure as required by this article.

2. The term of office of the members shall be three years; provided however, that of the members first appointed, three shall be appointed for a term which shall expire on June thirtieth, nineteen hundred seventy-one; four for a term which shall expire on June thirtieth, nineteen hundred seventy-two; and four for a term which shall expire on June thirtieth, nineteen hundred seventy-three; and provided however, that of the members first appointed on the expansion of the board to

thirteen members, one shall be appointed for a term which shall expire on June thirtieth, nineteen hundred seventy-four; and one for a term which shall expire on June thirtieth, nineteen hundred seventy-six. No member shall serve for more than two consecutive terms. Before entering upon his term of office every board member shall file with the secretary of state the constitutional oath of office. Vacancies in the membership of the board, however created, shall be filled in the manner of the original appointment by the commissioner for the unexpired term. Any member may be removed by the commissioner for misconduct, incapacity, incompetence, or neglect of duty.

3. Each member of the board shall receive a per diem allowance as determined by the commissioner for the time spent in the performance of his official duties and shall be reimbursed for all proper traveling and incidental expenses in carrying out the provisions of this article.

4. The commissioner shall designate an officer or employee of the department to act as secretary to the board, who shall not be a member of the board.

5. The board at its first meeting to be held within thirty days after appointment, and annually thereafter at its first meeting in each year, shall organize and elect from its members a chairman.

6. The board, for the purpose of transacting its business, shall meet at least once every six months at times and places designated by resolution. Special meetings also may be held at such times as the board may elect, or on the call of the commissioner. A written notice of the time, place and purpose of any special meeting shall be mailed by the secretary to all members of the board at least fifteen days before the date of the meeting.

7. A majority of the members of the board shall constitute a quorum for the transaction of business at any meeting.

8. The commissioner shall establish an advisory council, broadly representative of the health professions and the public, to provide such

technical assistance as the board or the commissioner shall request. Members shall serve without compensation but shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

§ 2896-b. Rules and regulations; powers and duties. 1. The board, by a majority vote, shall adopt and amend rules and regulations, to be certified by the commissioner prior to filing with the secretary of state, to effectuate the provisions and purposes of this article, including but not limited to (a) standards for courses of study for nursing home administrators and for other instruction and training and for experience and general character of nursing home administrators, and (b) standards and procedures for examination, for the issuance, revocation and suspension of licenses and registrations of nursing home administrators and for the investigation of written charges and complaints filed with the board relating thereto.

2. The board may assess a civil penalty against a nursing home administrator for violation of or failure to comply with any lawful notice, order or rule or regulation issued or adopted by the board, or any provision of this article, not exceeding one thousand dollars for every such violation or failure, which civil penalty may be assessed after a hearing pursuant to section twenty-eight hundred ninety-seven-a of this article.

3. The board, or the commissioner at the request of the board, shall conduct such continuing study and investigation of the quality and practice of nursing home administration as may be required for the improvement of the standards imposed and procedures required for the licensing of nursing home administrators, including the desirability of instituting a residency or preceptorship program for nursing home administrators in training.

4. The board, or the commissioner at the request of the board, shall conduct such study and investigation of higher education in institutional administration at the baccalaureate and master's degree

levels as is necessary to determine if such be required to assure the continuing maintenance of professional standards of nursing home administration in the state. The board shall seek the advice and counsel of the state department of education in the conduct of such studies.

5. The commissioner may propose rules and regulations and amendments thereto for consideration by the board to effectuate the purposes of this article.

6. The board shall also have the authority to take such actions as may be necessary to enable the state to meet the requirements set forth in section one thousand nine hundred eight of the social security act, the federal rules and regulations promulgated thereunder and other pertinent federal authority.

§ 2896-c. Qualifications of applicants for licensure. 1. An applicant shall be eligible for a license as provided in this article upon payment to the department of an application fee of forty dollars and the submission of satisfactory evidence, verified by oath or affirmation, that the applicant:

(a) is at least twenty-one years of age;

(b) is of good moral character and suitability;

(c) has successfully completed a four-year course of study in a secondary school approved by the board of regents or been issued a certificate of equivalency; and

(d) has satisfactorily completed a course of study in the field of institutional administration approved by the board or in a school licensed by the state department of education as maintaining a satisfactory standard, or an equivalent combination of instruction, training or experience as determined by the board, or the equivalent of such a course of study in a college as determined by the state department of education; and

(e) has passed an examination as specified in section two thousand eight hundred ninety-six-d of this title.

2. An applicant who is denied licensure only because of his failure to

meet the requirements of paragraphs (c) and (d) of subdivision one of this section may petition the board for reconsideration and may be licensed provided that he possesses educational qualifications or experience in nursing home administration which are at least the equivalent of the satisfactory completion of an approved course of study, and such extended practical experience in nursing home administration or in a related health administration activity as may be acceptable to the board.

§ 2896-d. Examination of applicants. 1. Applicants for licensure as nursing home administrators shall be required to pass an examination encompassing the subject matter of the courses of study, instruction, training and experience required by the board and certified by the commissioner.

2. The examination may be administered by the department or by another testing service certified by the commissioner pursuant to subdivision one of this section. The applicant shall be responsible for all fees charged by the authorized testing service for the administration of the examination.

3. The department may require applicants to demonstrate eligibility for licensure in accordance with section two thousand eight hundred ninety-six-c of this title prior to taking the examination.

4. Following such examinations, the board shall review and rate the examination results and shall submit to the department an official report signed by its chairman and secretary stating the ratings of each applicant and naming all applicants who successfully passed the examination.

5. The board may accept in lieu of the requirements in paragraph (e) of subdivision one of section two thousand eight hundred ninety-six-c of this title, a certificate, registration or license issued by another state or political subdivision of the United States on the basis of qualifications and an examination satisfactory to the board. The

application fee shall accompany an application for persons.

§ 2896-e. Issuance of license. 1. The board shall issue a license to practice nursing home administration to each candidate who meets the qualifications specified in section two thousand eight hundred ninety-six-c of this title or submitted an application and qualified under subdivision five of section two thousand eight hundred ninety-six-d of this title and who has paid an initial application fee.

2. Each license issued shall be signed by the chairman and the secretary of the board and shall bear the seal of the department.

3. Upon receipt of satisfactory evidence that a license has been lost, mutilated or destroyed, the board may issue a duplicate license upon such terms and conditions as may be required by the board and certified by the commissioner, and upon payment of a fee of ten dollars.

4. Notwithstanding the provisions of this article the board may adopt rules and regulations governing operation of a nursing home during periods of emergency.

§ 2896-f. Temporary licenses. The board may issue a temporary license to practice nursing home administration, under such conditions and limitations as it shall determine, for a single period not to exceed six months to an applicant of good moral character and suitability, over twenty-one years of age, who meets such other standards as are established by the board, who has paid an application fee of forty dollars and who is designated by the owner, operator or other governing authority to administer a facility during a period when due to resignation, death or incapacity or for other reason the position of nursing home administrator has been unexpectedly vacated.

§ 2896-g. Registration. 1. Every licensee must register biennially with the department. The department shall mail to every person who has

received a license under this article an application form for registration requesting such information as the board and the commissioner may require. Such licensee shall promptly fill out, sign and forward such application to the department, together with a fee of forty dollars; however, initial registration shall not require such fee. Upon receipt and approval of such application and fee, the department shall issue a certificate of biennial registration. The commissioner shall establish by rule and regulation the beginning date of the biennial registration period. In the event that a change in the established beginning date of the biennial registration period requires an adjustment in the duration of a registration period, there shall be a proportionate adjustment in the prescribed fee.

2. Licensees who apply for registration subsequent to the first year of any biennial registration period shall pay a fee of twenty dollars; however, initial registration shall not require such fee; upon receipt and approval of such application and fee, the department shall issue a certificate of registration for the balance of the biennial registration period.

3. Registration subsequent to the thirty-first day of December, nineteen hundred seventy-three, shall require satisfactory completion of such continuation education programs or courses of study as the board shall determine are required to assure the licensee's retention of professional competence in nursing home administration and development of necessary different, new or advanced nursing home administration skills and techniques.

4. A nursing home administrator who fails or neglects to apply for registration before the first day of the next ensuing biennial registration period as required by the provisions of this section shall be required to pay for registration an additional fee of five dollars for each month or part thereof that he is in default, provided, however, that the additional fee shall not be more than one hundred twenty dollars.

5. A practicing nursing home administrator who fails to apply and

qualify for registration before the first day of the next ensuing biennial registration period, shall be an illegal practitioner whose license may be suspended or revoked and who may be subjected to a civil penalty, censured or reprimanded by the board in accordance with the provisions of this article.

6. No person shall be entitled to register as a nursing home administrator unless he shall hold a license as provided for in this article. Every unrevoked certificate of registration issued as provided in this article shall be presumptive evidence in all courts and places that the person named therein is legally registered.

7. A nursing home administrator who has been heretofore duly licensed and registered to practice in this state whose license shall not have been revoked or suspended, and who either before or after registration, as required by this section, shall have temporarily abandoned the practice of nursing home administration and surrendered his registration certificate, may reregister within this state upon complying with the provisions of this section for registration, including payment of any fees due as of the date of surrender.

8. Upon receipt of satisfactory evidence that a certificate of registration has been lost, mutilated or destroyed, the department may issue a duplicate certificate upon such terms and conditions as the board shall prescribe with the approval of the commissioner, and upon the payment of a fee of ten dollars.

§ 2896-h. Reports. 1. Every administrator of a nursing home shall:

(a) post in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public, a concise summary of the last inspection report pertaining to the nursing home and issued by the department, with references to the page numbers of the full reports, noting any deficiencies found by said governmental agency or department and the actions taken by the nursing home to rectify such deficiencies, and indicating in such summaries where the full reports may be inspected in said nursing home;

(b) provide to each applicant and, upon request, to each resident of such nursing home, or any relative, spouse, guardian, committee or conservator of such applicant or resident, a copy of the last inspection report pertaining to the nursing home and issued by the department.

2. The license or registration of a nursing home administrator who violates any of the provisions of this section shall be subject to suspension or revocation and the nursing home administrator may be subject to a civil penalty in proceedings held in accordance with the provisions of section twenty-eight hundred ninety-seven-a of this article.

3. Nothing contained in this section shall be construed or deemed to require the public disclosure of confidential medical, social, personal or financial records of any patient. The commissioner shall adopt such regulations as may be necessary to give effect to the provisions of this section and to preserve the confidentiality of medical, social, personal or financial records of patients.

TITLE III

VIOLATIONS; PENALTIES

Section 2897. Suspension, revocation and civil penalties.

2897-a. Proceedings for suspension or revocation.

2897-b. Penalties.

2897-c. Disposition of fees, fines, penalties and other moneys.

2897-d. Injunctive relief.

§ 2897. Suspension, revocation and civil penalties. 1. The license or registration of a nursing home administrator may be suspended for a fixed period, revoked or annulled, or such administrator censured, reprimanded, subjected to a civil penalty and otherwise disciplined, in accordance with the provisions and procedures defined in this article, upon decision after due hearing that:

(a) he is guilty of fraud or deceit in his practice or has been guilty of fraud or deceit in procuring his license or registration;

(b) he has been convicted in a court of competent jurisdiction, either within or without the state, of a crime involving moral turpitude;

(c) he is or has been an alcohol abuser or is or has been addicted to the use of morphine, cocaine or other drugs having similar effect, or has become mentally ill;

(d) he has aided and abetted in the practice of nursing home administration a person who is not a registered nursing home administrator;

(e) he has falsely impersonated a duly registered nursing home administrator or former duly registered nursing home administrator, or is practicing nursing home administration under an assumed name;

(f) he has been guilty of unethical conduct as defined by rules adopted by the board and certified by the commissioner;

(g) he has not obtained a certificate of registration as required by section two thousand eight hundred ninety-six-g.

2. (a) A conviction of a felony shall forfeit a license to practice nursing home administration and shall be noted on the record of such license, and the license and registration thereunder shall be cancelled; provided, that if such conviction be subsequently set aside or reversed upon appeal and the accused acquitted or discharged, his license shall be restored.

(b) A conviction of a felony shall include the conviction of a felony by any court in this state or by any court of the United States or by any court of any other state of the United States; provided, however, that if a crime of which the practitioner of nursing home administration is convicted by any court of the United States or any other state is a felony in the jurisdiction in which the conviction is had but is not a felony in the state of New York, then the conviction shall not be deemed a conviction of a felony for the purpose of this article. In the event that a crime of which the licensee is convicted by any court of the United States or by any court of any other state is not a felony in the jurisdiction in which the conviction is had but is a felony in the state of New York, then the conviction shall be deemed a conviction of a felony for the purposes of this article.

(c) If a person convicted of a felony or crime deemed hereby to be a felony is subsequently pardoned by the governor of the state where such

conviction was had, or by the president of the United States, or shall receive a certificate of relief from disabilities or a certificate of good conduct pursuant to article twenty-three of the correction law for the purpose of removing the disability under this section because of such conviction, the board may, in its discretion, on application of such person, and on the submission to it of satisfactory evidence, restore to such person the right to practice nursing home administration in this state.

3. The license or registration of a nursing home administrator may be suspended for a fixed period or revoked or such administrator may be censured, reprimanded, subjected to a civil penalty and otherwise disciplined in accordance with the provisions and procedures defined in this article, upon decision after due hearing that, as the administrator of a nursing home he has intentionally participated in any act, practice or policy of such nursing home that endangered the health or safety of its patients. No administrator shall be deemed to have intentionally participated in any act, practice or policy of a nursing home if he has filed written objection to such act, practice or policy with the operator of such nursing home, specifying the manner in which such act, practice or policy endangers the health or safety of the patients of such nursing home.

§ 2897-a. Proceedings for suspension or revocation. 1. Proceedings against any licensed or registered nursing home administrator under this section shall be begun by filing with the board a written charge or charges in the form of a petition under oath against such nursing home administrator. The charges may be preferred by any person, corporation, association or public officer, or by the board or department in the first instance. A report of such investigation as the department shall deem proper shall be provided on request of the board.

2. If the board decides that the charges should be heard, the board shall designate a hearing officer to hear and report on the charges and shall set a time and place for the hearing. A copy of the charges, together with a notice of the time and place of hearing, shall be served

on the accused at least fifteen days before the date fixed for the hearing personally in the same manner as a summons in a civil action, or by certified or registered mail addressed to the last known address of the licensee.

3. The respondent in all such cases brought under this section shall, at least five days before the return date of the petition containing the charges, file with the board a verified answer, in duplicate, to the allegations set forth in said petition. The accused shall have the opportunity at such hearing to appear either personally or by counsel, to cross-examine witnesses against him and to produce evidence and witnesses in his defense.

4. Upon the conclusion of the hearing, the hearing officer shall make a written report of his findings and conclusions to the board. The board shall thereupon take such action upon said findings and conclusions as it deems proper. If the accused is found not guilty by the board, it shall order a dismissal of the charges and his exoneration. If the accused is found guilty of the charges, or any of them, the board shall, in its discretion, issue an order suspending, revoking or annulling the license or registration of the accused, assessing a civil penalty and otherwise disciplining him.

5. Where the license or registration of any person has been revoked or annulled, as herein provided, the board may, after the expiration of two years, entertain an application for restoration of such license or registration.

6. A licensed nursing home administrator whose license or registration has been suspended, revoked or annulled, or who is otherwise disciplined under this article, may commence a proceeding under article seventy-eight of the civil practice law and rules in the supreme court, Albany county, for the purpose of reviewing such determination, but no such determination shall be stayed or enjoined except after notice to the attorney general of the commencement of the proceeding.

§ 2897-b. Penalties. 1. It shall be a misdemeanor for a person to:

(a) sell or fraudulently obtain or furnish a nursing home administrator diploma, license, record, or certificate of registration, or aid or abet in the same;

(b) practice nursing home administration under cover of a diploma, license or registration illegally or fraudulently obtained or signed or issued unlawfully, or under fraudulent representation or mistake of fact in material regard;

(c) practice or hold himself out as entitled to practice nursing home administration without a valid license or after he shall have been convicted of a felony;

(d) practice fraud, subterfuge or deceit, misrepresent or conceal a material fact, use a false name or wilfully make a false statement in submitting an application for licensure or registration.

(e) otherwise violate any of the provisions of this article.

2. Such misdemeanor shall be punishable by imprisonment for not more than one year or by a fine of not more than five thousand dollars, or by both such fine and imprisonment for each separate violation.

3. A violation of this article, when reported to the department and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and, if the report is found to be true and the complaint substantiated, the board shall report such violation to the attorney general and request prompt prosecution.

4. In the prosecution of any criminal action for violation of this article by the attorney general or his deputy, the attorney general or his deputy may exercise all the powers and perform all the duties with respect to such actions or proceedings which the district attorney would otherwise be authorized or required to exercise or perform, and in such action or proceeding the district attorney shall only exercise such powers and perform such duties as are required of him by the attorney general or the deputy attorney general so attending.

§ 2897-c. Disposition of fees, fines, penalties and other moneys. All

fees, fines, penalties and other moneys derived from the operation of this article shall be paid to the department and shall be paid by the department to the state treasury, as provided in the state finance law.

§ 2897-d. Injunctive relief. The attorney general may apply to the supreme court within the judicial district in which a violation of this article is alleged to have occurred for an order enjoining or restraining commission or continuance of the acts complained of. Thereupon the court shall have jurisdiction of the proceeding and shall have power to grant such temporary relief or restraining order as it deems just and proper. In any such proceeding it shall be unnecessary to allege or prove that an adequate remedy at law does not exist or that irreparable damage would result if such order were not granted. The remedy provided by this section shall be in addition to any other remedy provided by law.

TITLE IV **CONSTRUCTION**

Section 2898. Construction.

2898-a. Separability.

§ 2898. Construction. Nothing in this article shall be construed to limit the activities, services, and use of official title on the part of any person, provided that no title shall be used which includes the term or words "licensed nursing home administrator" by any person not qualified to do so under the provisions of this article.

§ 2898-a. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the

controversy in which the judgment shall have been rendered.

ARTICLE 28-E
**REVIEW OF CRIMINAL HISTORY
INFORMATION CONCERNING PROSPECTIVE
EMPLOYEES OF NURSING
HOMES AND HOME CARE
SERVICES AGENCIES**

Section 2899. Definitions.

2899-a. Requests for criminal history information concerning prospective employees.

§ 2899. Definitions. As used in this article, the following words and phrases shall have the following meanings:

1. "Criminal history information" shall mean a record of pending criminal charges, criminal convictions which have not been vacated or reversed, information from the federal bureau of investigation as a result of a national criminal history record check, and certificates filed pursuant to subdivision two of section seven hundred five of the correction law and which the division of criminal justice services is required to maintain pursuant to subdivision six of section eight hundred thirty-seven of the executive law.

2. "Determination" shall mean the decision made by the department after reviewing criminal history information to approve or disapprove a prospective employee's eligibility for employment by a provider. All such determinations shall be made in accordance with subdivision five of section eight hundred forty-five-b of the executive law.

3. "Employee" shall mean any person to be employed or used by a provider, including those persons employed by a temporary employment agency, to provide direct care or supervision to patients or residents. Persons licensed pursuant to title eight of the education law or article twenty-eight-D of this chapter are excluded from the meaning of employee

under this article. Such term shall not include volunteers.

4. "Permanent record" shall mean a permanent, written record of a determination and the criminal history information maintained by the department.

5. "Prospective employee" shall mean any individual, not currently an employee, who files an application for employment as an employee with a provider and the provider has a reasonable expectation to hire such individual as an employee.

* 6. "Provider" shall mean: (a) any residential health care facility licensed under article twenty-eight of this chapter; or any certified home health agency, licensed home care services agency or long term home health care program certified under article thirty-six of this chapter; any hospice program certified pursuant to article forty of this chapter; or any adult home, enriched housing program or residence for adults licensed under article seven of the social services law; or (b) a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services, including enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law; or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act.

* NB Effective until March 31, 2032

* 6. "Provider" shall mean any residential health care facility licensed under article twenty-eight of this chapter; or any certified home health agency, licensed home care services agency or long term home health care program certified under article thirty-six of this chapter; or any adult home, enriched housing program or residence for adults licensed under article seven of the social services law.

* NB Effective March 31, 2032

7. "Temporary employee" shall mean any employee who has been temporarily approved for employment pending a determination by the department.

§ 2899-a. Requests for criminal history information concerning prospective employees. 1. A provider shall request that the department check, and upon such request the department shall check its permanent record according to this section for a determination on a prospective employee. If a permanent record does not exist for the prospective employee, the department shall be authorized to request and receive criminal history information concerning the prospective employee from the division of criminal justice services in accordance with the provisions of section eight hundred forty-five-b of the executive law. Access to and the use of such information shall be governed by the provisions of such section. The division of criminal justice services is authorized to submit fingerprints to the federal bureau of investigation for a national criminal history record check.

2. To the extent permitted by law, a provider shall request from a prospective employee a sworn statement disclosing any prior finding of patient or resident abuse, or a criminal conviction in this state or any other jurisdiction. Providers shall evaluate such statements in all hiring decisions, including any temporary approvals allowed under subdivision eleven of section eight hundred forty-five-b of the executive law and subdivision ten of this section.

3. No person who has been fingerprinted pursuant to this article and whose fingerprints remain on file with the division of criminal justice services shall be required to undergo fingerprinting for purposes of a new state check required by this article.

4. The commissioner shall promulgate all rules and regulations necessary to implement the provisions of this article, which shall include convenient procedures for prospective employees to promptly verify the accuracy of their criminal history information and, to the

extent authorized by law, to have access to relevant documents related thereto.

5. Nothing in this article shall be construed or interpreted to in any way diminish the integrity of any collective bargaining agreement negotiated on or before April first, two thousand five between an employer and any certified or authorized collective bargaining agent for employees, or to diminish rights which accrue to such employees pursuant to such agreements.

6. The department may accept digital fingerprint images or any other acceptable technological devices used to obtain and/or transmit fingerprint images for the purposes of this article, as provided for in the rules and regulations created by the commissioner pursuant to subdivision four of this section. To the extent funds are available therefor, grants to assist and facilitate the purchase of technology shall be made available to providers who demonstrate the need for financial assistance as determined by the department.

7. The department promptly shall make all determinations and actions required by subdivision five of section eight hundred forty-five-b of the executive law upon receipt of the information from the division of criminal justice services and the federal bureau of investigation, provided that when rendering a determination to propose denial of employment eligibility, the department shall provide the individual who is the subject of the criminal history information check with a copy of such criminal history information and a copy of article twenty-three-A of the correction law and inform such individual of his or her right to seek correction of any incorrect information contained in such criminal history information pursuant to the regulations and procedures established by the division of criminal justice services. The department shall create a permanent record, update the information in accordance with section eight hundred forty-five-b of the executive law and make only records or information received from the division of criminal justice services available to providers pursuant to this section.

8. The department shall allow all providers access to any

determination made upon a prospective employee at such time as such prospective employee presents himself or herself to such provider for employment. In the event that the prospective employee has a permanent record already on file with the department, this information promptly shall be made available to the provider who intends to hire such prospective employee.

9. * (a) In the event that funds are appropriated in any given fiscal year for the reimbursement for the costs of providing such criminal history information, reimbursement shall be made available in an equitable and direct manner for the projected cost of the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints to all providers licensed, but not certified under article thirty-six of this chapter, providers certified under article forty of this chapter, and all adult care facilities licensed under article seven of the social services law, including those that are subject to this article and are unable to access direct reimbursement from state and/or federal funded health programs.

* NB Effective until March 31, 2029

* (a) In the event that funds are appropriated in any given fiscal year for the reimbursement for the costs of providing such criminal history information, reimbursement shall be made available in an equitable and direct manner for the projected cost of the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints to all providers licensed, but not certified under article thirty-six of this chapter, and all adult care facilities licensed under article seven of the social services law, including those that are subject to this article and are unable to access direct reimbursement from state and/or federal funded health programs.

* NB Effective March 31, 2029

(b) Residential health care facilities licensed pursuant to article

twenty-eight of this chapter and certified home health care agencies and long-term home health care programs certified or approved pursuant to article thirty-six of this chapter or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services, including enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law; or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act, may, subject to the availability of federal financial participation, claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints, provided, however, that for the purposes of determining rates of payment pursuant to article twenty-eight of this chapter for residential health care facilities, such reimbursable fees and costs shall be reflected as timely as practicable in such rates within the applicable rate period.

10. Notwithstanding subdivision eleven of section eight hundred forty-five-b of the executive law, a certified home health agency, licensed home care services agency or long term home health care program certified, licensed or approved under article thirty-six of this chapter or a home care services agency exempt from certification or licensure under article thirty-six of this chapter, a hospice program under article forty of this chapter, or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services, including enrollees

who are under twenty-one years of age, under section three hundred sixty-five-1 of the social services law, except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law; or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act may temporarily approve a prospective employee while the results of the criminal history information check and the determination are pending, upon the condition that the provider conducts appropriate direct observation and evaluation of the temporary employee, while he or she is temporarily employed, and the care recipient; provided, however, that for a health home, or any subcontractor of a health home, who contracts with or is approved or otherwise authorized by the department to provide health home services, including enrollees who are under twenty-one years of age, under section three hundred sixty-five-1 of the social services law, except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law; or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act, direct observation and evaluation of temporary employees shall not be required until July first, two thousand nineteen. The results of such observations shall be documented in the temporary employee's personnel file and shall be maintained. For purposes of providing such appropriate direct observation and evaluation, the provider shall utilize an individual employed by such provider with a minimum of one year's experience working in an agency certified, licensed or approved under article thirty-six of this chapter or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, a health home, or any subcontractor of such health home, who

contracts with or is approved or otherwise authorized by the department to provide health home services, including enrollees who are under twenty-one years of age, under section three hundred sixty-five-l of the social services law, except for a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law; or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act. If the temporary employee is working under contract with another provider certified, licensed or approved under article thirty-six of this chapter, such contract provider's appropriate direct observation and evaluation of the temporary employee, shall be considered sufficient for the purposes of complying with this subdivision.

11. No provider shall seek, directly or indirectly, to obtain from a prospective employee, temporary employee or employee compensation in any form for the payment of the fee or any facility costs associated with obtaining the criminal history information check required by this article.

12. This article shall be deemed to supersede and apply in lieu of any local laws or laws of any political subdivision of the state or any regulations of the department requiring a criminal history record check to the extent provided for in this article.

ARTICLE 28-F

MEDICAL AID IN DYING

Section 2899-d. Definitions.

2899-e. Request process.

2899-f. Attending physician responsibilities.

2899-g. Right to rescind request; requirement to offer opportunity to rescind.

2899-h. Consulting physician responsibilities.
2899-i. Mental health professional responsibilities.
2899-j. Medical record documentation requirements.
2899-k. Form of written request and witness attestation.
2899-l. Protection and immunities.
2899-m. Permissible refusals and prohibitions.
2899-n. Relation to other laws and contracts.
2899-o. Safe disposal of unused medications.
2899-p. Death certificate.
2899-q. Reporting.
2899-r. Penalties.
2899-s. Severability.

§ 2899-d. Definitions. As used in this article:

1. "Adult" means an individual who is eighteen years of age or older.
2. "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal illness or condition.
3. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, including medical aid in dying, and to reach an informed decision.
4. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's terminal illness or condition.
5. "Health care facility" means a general hospital, nursing home, or residential health care facility as defined in section twenty-eight hundred one of this chapter, or a hospice as defined in section four thousand two of this chapter.

6. "Health care provider" means an individual licensed, certified, or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

7. "Informed decision" means a decision by a patient who is suffering from a terminal illness or condition to request and obtain a prescription for medication that the patient may self-administer to end the patient's life that is based on an understanding and acknowledgment of the relevant facts and that is made voluntarily, of the patient's own volition and without coercion, after being fully informed of:

(a) the patient's medical diagnosis and prognosis;

(b) the potential risks associated with taking the medication to be prescribed;

(c) the probable result of taking the medication to be prescribed;

(d) the possibility that the patient may choose not to obtain the medication, or may obtain the medication but may decide not to self-administer it; and

(e) the feasible alternatives and appropriate treatment options, including but not limited to palliative care and hospice care.

8. "Medical aid in dying" means the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death.

9. "Medically confirmed" means the medical opinion of the attending physician that a patient has a terminal illness or condition and has made an informed decision which has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

10. "Medication" means medication prescribed by a physician under this article.

11. "Mental health professional" means an individual (a) licensed to practice medicine in New York state who is a diplomate of the American board of psychiatry and neurology or is eligible to be certified by that board or is certified by the American osteopathic board of neurology and

psychiatry or is eligible to be certified by that board; or (b) licensed to practice psychology under title eight of the education law.

12. "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

13. "Patient" means a resident of New York state who is eighteen years of age or older under the care of a physician.

14. "Physician" means an individual licensed to practice medicine in New York state.

15. "Qualified individual" means a patient with a terminal illness or condition, who has decision-making capacity, has made an informed decision, and has satisfied the requirements of this article in order to obtain a prescription for medication.

16. "Self-administer" means a qualified individual's affirmative, conscious, and voluntary act to ingest medication under this article. Self-administration does not include lethal injection or lethal infusion.

17. "Terminal illness or condition" means an incurable and irreversible illness or condition that has been medically confirmed and will, within reasonable medical judgment, produce death within six months whether or not treatment is provided.

18. "Third-party health care payer" has its ordinary meaning and includes, but is not limited to, an insurer, organization or corporation licensed or certified under article thirty-two, forty-three or forty-seven of the insurance law, or article forty-four of the public health law; or an entity such as a pharmacy benefits manager or third-party administrator.

§ 2899-e. Request process. 1. Oral and written request. A patient wishing to request medication under this article shall make an oral request and submit a written request to the patient's attending physician. If a patient is not physically capable of making an oral request, such request can be made using an alternative method of communication familiar to the patient. Oral requests made under this subdivision must be recorded by an audio or video device and permanently stored in the patient's medical record.

2. Making a written request. A patient may make a written request for and consent to self-administer medication for the purpose of ending such patient's life in accordance with this article if the patient:

(a) has been determined by the attending physician to have a terminal illness or condition and which has been medically confirmed by a consulting physician; and

(b) based on an informed decision, requests voluntarily, of the patient's own volition and without coercion, medication to end such patient's life.

3. Written request signed and witnessed. (a) A written request for medication under this article shall be signed and dated by the patient and witnessed by at least two adults who, in the presence of the patient, attest that to the best of the persons knowledge and belief the patient has decision-making capacity, is acting voluntarily, is making the request for medication of the patient's own volition and is not being coerced to sign the request. The written request shall be in substantially the form described in section twenty-eight hundred ninety-nine-k of this article.

(b) Both witnesses shall be adults who are not:

(i) a relative of the patient by blood, marriage or adoption;

(ii) a person who at the time the request is signed would be entitled to any portion of the estate of the patient upon death under any will or by operation of law or would otherwise benefit financially from the death of the patient;

(iii) an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a

resident;

(iv) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of this chapter;

(v) an agent under the patient's health care proxy as defined in subdivision five of section twenty-nine hundred eighty of this chapter; or

(vi) an agent acting under a power of attorney for the patient as defined in section 5-1501 of the general obligations law.

(c) The attending physician, consulting physician and the mental health professional who provides a decision-making capacity determination of the patient under this article shall not be a witness.

4. No person shall qualify for medical aid in dying under this article solely because of age or disability.

5. Requests for a medical aid-in-dying prescription must be made by the qualified individual and may not be made by any other individual, including the qualified individual's health care agent, or other agent or surrogate, or via advance healthcare directive.

§ 2899-f. Attending physician responsibilities. 1. Upon a patient's request for a medical aid-in-dying prescription, the attending physician shall examine the patient in person and the patient's relevant medical records, provided, however, that the attending physician may waive the in-person examination requirement and conduct the examination via telehealth if the physician determines, within reasonable medical judgment, and documents in the patient's medical record that requiring an in-person visit would result in extraordinary hardship to the patient. For purposes of this subdivision, the term "extraordinary hardship" shall mean circumstances in which an in-person examination would cause the patient undue pain or suffering, or would necessitate extraordinary expense or logistical burden for medically-necessary transportation. In such cases, the examination may be conducted via telehealth once the attending physician affirms that all other requirements of this article have been fulfilled. The attending physician shall also:

(a) make a determination of whether a patient has a terminal illness or condition, has decision-making capacity, has made an informed decision and has made the request voluntarily of the patient's own volition and without coercion;

(b) inform the patient of the requirement under this article for confirmation by a consulting physician, and refer the patient to a consulting physician upon the patient's request;

(c) inform the patient of the requirement under this article for confirmation by a mental health professional, and refer the patient to a mental health professional upon the patient's request;

(d) provide information and counseling under section twenty-nine hundred ninety-seven-c of this chapter, provided, however, that if the attending physician is not willing or does not feel qualified to provide the patient with information and counseling under this paragraph, the attending physician may arrange for another physician to do so, or shall refer or transfer the patient to another physician willing to do so;

(e) ensure that the patient is making an informed decision by discussing with the patient: (i) the patient's medical diagnosis and prognosis; (ii) the potential risks associated with taking the medication to be prescribed; (iii) the probable result of taking the medication to be prescribed; (iv) the possibility that the patient may choose to obtain the medication but not take it; (v) the feasible alternatives and appropriate treatment options, including but not limited to (1) information and counseling regarding palliative and hospice care and end-of-life options appropriate to the patient, including but not limited to: the range of options appropriate to the patient; the prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management at the end of life; and (2) information regarding treatment options appropriate to the patient, including the prognosis, risks and benefits of the various treatment options;

(f) offer to refer the patient for other appropriate treatment options, including but not limited to palliative care and hospice care;

(g) provide health literate and culturally appropriate educational material regarding hospice and palliative care that has been prepared by the department in consultation with representatives of hospice and palliative care providers from all regions of New York state, and that

is available on the department's website for access and download, provided, however, an otherwise eligible patient cannot be denied care under this article if these materials are not developed by the effective date of this article;

(h) discuss with the patient the importance of:

(i) having another person present when the patient takes the medication and the restriction that no person other than the patient may administer the medication;

(ii) not taking the medication in a public place; and

(iii) informing the patient's family of the patient's decision to request and take medication that will end the patient's life; a patient who declines or is unable to notify family shall not have such patient's request for medication denied for that reason;

(i) inform the patient that such patient may rescind the request for medication at any time and in any manner;

(j) fulfill the medical record documentation requirements of section twenty-eight hundred ninety-nine-j of this article; and

(k) ensure that all appropriate steps are carried out in accordance with this article before writing a prescription for medication.

2. Upon receiving confirmation from a consulting physician and mental health professional under section twenty-eight hundred ninety-nine-h of this article and section twenty-eight hundred ninety-nine-i of this article, respectively, the attending physician who determines that the patient has a terminal illness or condition, has decision-making capacity and has made a voluntary request for medication as provided in this article, may personally, or by referral to another physician, prescribe or order appropriate medication in accordance with the patient's request under this article, and at the patient's request, facilitate the filling of the prescription and delivery of the medication to the patient.

3. A prescription for medication shall not be filled until five days after the prescription has been written, unless the patient's attending physician has medically confirmed that the qualified individual may, within reasonable medical judgment, die before the expiration of the waiting period identified herein, in which case, the prescription may be

filled once the attending physician affirms that all other requirements pursuant to this article have been fulfilled. Such prescription must indicate the date and time that the prescription for medication was written and indicate the first allowable date and time when it may be filled.

4. In accordance with the direction of the prescribing or ordering physician and the consent of the patient, the patient may self-administer the medication to themselves. A health care professional or other person shall not administer the medication to the patient.

§ 2899-g. Right to rescind request; requirement to offer opportunity to rescind. 1. A patient may at any time rescind the request for medication under this article without regard to the patient's decision-making capacity.

2. A prescription for medication may not be written without the attending physician offering the qualified individual an opportunity to rescind the request.

§ 2899-h. Consulting physician responsibilities. Before a patient who is requesting medication may receive a prescription for medication under this article, a consulting physician must:

1. examine the patient and such patient's relevant medical records;
2. confirm, in writing, to the attending physician and the patient, whether: (a) the patient has a terminal illness or condition; (b) the patient is making an informed decision; (c) the patient has decision-making capacity; and (d) the patient is acting voluntarily, of the patient's own volition and without coercion.

§ 2899-i. Mental health professional responsibilities. 1. Before a patient who is requesting medication may receive a prescription for

medication under this article, a mental health professional must evaluate the patient and report, in writing, to the attending physician and the consulting physician, the mental health professional's independent conclusions about whether the patient has decision-making capacity to make an informed decision, provided that if, at the time of the report, the patient has not yet been referred to a consulting physician, then upon referral the attending physician shall provide the consulting physician with a copy of the mental health professional's report. If the mental health professional determines that the patient lacks decision-making capacity to make an informed decision, the patient shall not be deemed a qualified individual, and the attending physician shall not prescribe medication to the patient.

2. A determination made pursuant to this section that an adult patient lacks decision-making capacity shall not be construed as a finding that the patient lacks decision-making capacity for any other purpose.

§ 2899-j. Medical record documentation requirements. An attending physician shall document or file the following in the patient's medical record:

1. the dates of all oral requests by the patient for medication under this article;

2. the written request by the patient for medication under this article, including the declaration of witnesses and interpreter's declaration, if applicable;

3. the attending physician's diagnosis and prognosis, determination of decision-making capacity, and determination that the patient is acting voluntarily, of the patient's own volition and without coercion, and has made an informed decision;

4. written determination of decision-making capacity under section twenty-eight hundred ninety-nine-i of this article; and

5. a note by the attending physician indicating that all requirements under this article have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed or ordered.

§ 2899-k. Form of written request and witness attestation. 1. A request for medication under this article shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

I, _____, am an adult who has decision-making capacity, which means I understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision and to communicate health care decisions to a physician.

I have been diagnosed with (insert diagnosis), which my attending physician has determined is a terminal illness or condition, which has been medically confirmed by a consulting physician and mental health professional and will, in the judgment of the physicians and mental health professional, produce death within six months whether or not treatment is provided.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives and treatment options including but not limited to palliative care and hospice care.

I request that my attending physician prescribe medication that will end my life if I choose to take it, and I authorize my attending physician to contact another physician or any pharmacist about my request.

INITIAL ONE:

() I have informed or intend to inform one or more members of my

family of my decision.

() I have decided not to inform any member of my family of my decision.

() I have no family to inform of my decision.

I understand that I have the right to rescind this request or decline to use the medication at any time.

I understand the importance of this request, and I expect to die if I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I make this request voluntarily, of my own volition and without being coerced, and I accept full responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

I declare that the person signing this "Request for Medication to End My Life":

(a) is personally known to me or has provided proof of identity;

(b) voluntarily signed the "Request for Medication to End My Life" in my presence or acknowledged to me that the person signed it; and

(c) to the best of my knowledge and belief, has decision-making capacity and is making the "Request for Medication to End My Life" voluntarily, of the person's own volition and is not being coerced to sign the "Request for Medication to End My Life".

I am not the attending physician or consulting physician of the person signing the "Request for Medication to End My Life" or the mental health professional who provides a decision-making capacity determination of the person signing the "Request for Medication to End My Life" at the time the "Request for Medication to End My Life" was signed.

I further declare under penalty of perjury that the statements made herein are true and correct and false statements made herein are

punishable.

I further declare that I am not (i) related to the above-named patient by blood, marriage or adoption; (ii) entitled at the time the patient signed the "Request for Medication to End My Life" to any portion of the estate of the patient upon such patient's death under any will or by operation of law, or otherwise in a position to benefit financially from the patient's death; (iii) an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident; (iv) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of the public health law; (v) an agent, as defined in subdivision five of section twenty-nine hundred eighty of the public health law, under the patient's health care proxy; or (vi) an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient.

Witness 1, Date:

(Printed name)

(Address)

(Telephone number)

Witness 2, Date:

(Printed name)

(Address)

(Telephone number)

2. (a) The "Request for Medication to End My Life" shall be written in the same language as any conversations, consultations, or interpreted conversations or consultations between a patient and at least one of the patient's attending or consulting physicians.

(b) Notwithstanding paragraph (a) of this subdivision, the written "Request for Medication to End My Life" may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English or with auxiliary aids or hearing, speech or visual aids, if the English language form includes an attached declaration by the interpreter of the conversation or consultation, which shall be in substantially the following form:

INTERPRETER'S DECLARATION

I, (insert name of interpreter), (mark as applicable):

() for a patient whose conversations or consultations or interpreted conversations or consultations were conducted in a language other than English and the "Request for Medication to End My Life" is in English: I declare that I am fluent in English and (insert target language). I have the requisite language and interpreter skills to be able to interpret effectively, accurately and impartially information shared and communications between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I interpreted the communications and information conveyed between the physician and (name of patient) as accurately and completely to the best of my knowledge and ability and read the "Request for Medication to End My Life" to (name of patient) in (insert target language).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

() for a patient with a speech, hearing or vision disability: I declare that I have the requisite language, reading and/or interpreter skills to communicate with the patient and to be able to read and/or interpret effectively, accurately and impartially information shared and communications that occurred on (insert date) between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I read and/or interpreted the communications and information conveyed between the physician and (name of patient) impartially and as accurately and completely to the best of my knowledge and ability and, where needed for effective communication, read or interpreted the "Request for Medication to End my Life" to (name of patient).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

I further declare under penalty of perjury that (i) the foregoing is true and correct; (ii) I am not (A) related to (name of patient) by blood, marriage or adoption; (B) entitled at the time (name of patient) signed the "Request for Medication to End My Life" to any portion of the estate of (name of patient) upon such patient's death under any will or by operation of law, or otherwise in a position to benefit financially from the patient's death; (C) an owner, operator, employee or independent contractor of a health care facility where (name of patient) is receiving treatment or is a resident, except that if I am an employee or independent contractor at such health care facility, providing interpreter services is part of my job description at such health care facility or I have been trained to provide interpreter services and (name of patient) requested that I provide interpreter services to such patient for the purposes stated in this Declaration; (D) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of the public health law; (E) an agent, as defined in subdivision five of section twenty-nine hundred eighty of the public health law, under the patient's health care proxy; or (F) an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient; and (iii) false statements made herein are punishable.

Executed at (insert city, county and state) on this (insert day of month) of (insert month), (insert year).

(Signature of Interpreter)

(Printed name of Interpreter)

(ID # or Agency Name)

(Address of Interpreter)

(Language Spoken by Interpreter)

(c) An interpreter whose services are provided under paragraph (b) of this subdivision shall not (i) be related to the patient who signs the "Request for Medication to End My Life" by blood, marriage or adoption; (ii) be entitled at the time the "Request for Medication to End My Life" is signed by the patient to any portion of the estate of the patient upon death under any will or by operation of law, or otherwise in a position to benefit financially from the patient's death; (iii) be an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident;

provided that an employee or independent contractor whose job description at the health care facility includes interpreter services or who is trained to provide interpreter services and who has been requested by the patient to serve as an interpreter under this article shall not be prohibited from serving as an interpreter under this article; (iv) be a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of this chapter; (v) be an agent, as defined in subdivision five of section twenty-nine hundred eighty of this chapter, under the patient's health care proxy; or (vi) be an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient.

§ 2899-1. Protection and immunities. 1. A physician, pharmacist, other health care provider or other person shall not be subject to civil, administrative, or criminal liability or penalty or professional disciplinary action by any government entity for taking any reasonable good-faith action or refusing to act under this article, including, but not limited to: (a) engaging in discussions with a patient relating to the risks and benefits of end-of-life options in the circumstances described in this article, (b) providing a patient, upon request, with a referral to another health care provider, (c) being present when a qualified individual self-administers medication, (d) refraining from acting to prevent the qualified individual from self-administering such medication, or (e) refraining from acting to resuscitate the qualified individual after the qualified individual self-administers such medication.

2. A health care provider or other person shall not be subject to employment, credentialing, or contractual liability or penalty for any reasonable good-faith action or refusing to act under this article, including, but not limited to:

(a) engaging in discussions with a patient relating to the risks and benefits of end-of-life options in the circumstances described in this article;

(b) providing a patient, upon request, with a referral to another

health care provider;

(c) being present when a qualified individual self-administers medication;

(d) refraining from acting to prevent the qualified individual from self-administering such medication; or

(e) refraining from acting to resuscitate the qualified individual after the qualified individual self-administers such medication.

However, this subdivision does not bar a health care facility from acting under paragraph (c) of subdivision two of section twenty-eight hundred ninety-nine-m of this article.

3. Nothing in this section shall limit civil, administrative, or criminal liability or penalty or any professional disciplinary action, or employment, credentialing, or contractual liability or penalty for negligence, recklessness or intentional misconduct.

§ 2899-m. Permissible refusals and prohibitions. 1. (a) A physician, nurse, pharmacist, other health care provider or other person shall not be under any duty, by law or contract, to participate in the provision of medication to a patient under this article.

(b) If a health care provider is unable or unwilling to participate in the provision of medication to a patient under this article and the patient transfers care to a new health care provider, the prior health care provider shall transfer or arrange for the transfer, upon request, of a copy of the patient's relevant medical records to the new health care provider.

2. (a) A private health care facility may prohibit the prescribing, dispensing, ordering or self-administering of medication under this article while the patient is being treated in the health care facility or in an affiliated facility that is majority-owned, operated, or controlled by the same corporate entity as the health care facility, or while the patient is residing in the health care facility if:

(i) the prescribing, dispensing, ordering or self-administering is contrary to a formally adopted policy of the health care facility that is expressly based on sincerely held religious beliefs or moral

convictions central to the health care facility's operating principles; and

(ii) the health care facility has informed the patient of such policy prior to admission or as soon as reasonably possible.

(b) Where a health care facility has adopted a prohibition under this subdivision, if a patient who wishes to use medication under this article requests, the patient shall be transferred promptly to another health care facility that is reasonably accessible under the circumstances and willing to permit the prescribing, dispensing, ordering and self-administering of medication under this article with respect to the patient.

(b-1) A health care facility or an affiliated facility that is majority-owned, operated, or controlled by the same corporate entity as the health care facility that has adopted a prohibition under this subdivision may restrict any employee from participating in the provision of medication under this article.

(c) Where a health care facility has adopted a prohibition under this subdivision, any health care provider or employee or independent contractor of the health care facility or any facility that is majority-owned, operated, or controlled by the same corporate entity as the health care facility who violates the prohibition may be subject to sanctions otherwise available to the health care facility, provided the health care facility has previously notified the health care provider, employee or independent contractor of the prohibition in writing.

3. Nothing in this section shall be construed to restrict a patient at home from accessing care under this article.

§ 2899-n. Relation to other laws and contracts. 1. (a) A patient who requests medication under this article shall not, because of that request, be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose.

(b) Action taken in accordance with this article shall not be construed for any purpose to constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, euthanasia, mercy

killing, or homicide under the law, including as an accomplice or accessory or otherwise.

2. (a) No provision in a contract, other agreement or testamentary instrument, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication or take any other action under this article, shall be valid.

(b) No obligation owing under any contract, other agreement or testamentary instrument shall be conditioned or affected by the making or rescinding of a request by a person for medication or taking any other action under this article.

3. (a) A person and such person's beneficiaries shall not be denied benefits under a life insurance policy for actions taken in accordance with this article.

(b) The sale, procurement or issuance of a life insurance or annuity policy or third-party health care payer policy or coverage, or the rate charged for a policy or coverage, shall not be conditioned upon or affected by a patient making or rescinding a request for medication under this article.

(c) This article shall not limit the effect of a life insurance policy provision concerning incontestability pursuant to article thirty-two of the insurance law or any rights or obligations concerning a material misrepresentation in accordance with article thirty-one of the insurance law.

(d) No third-party health care payer may deny coverage for any service or item that would otherwise be covered by the policy because the patient has or has not chosen to request or use medication under this article.

4. An insurer or third-party health care payer shall not provide any information in communications made to a patient about the availability of medication under this article absent a request by the patient or by such patient's attending physician upon the request of such patient. Any communication from an insurer or third-party health care payer indicating a denial of coverage for treatment shall not also include any information as to the availability of medication prescribed under this

article. This subdivision does not bar the inclusion of information as to the coverage of medication and professional services under this article in information generally stating what is covered by a third-party health care payer or provided in response to a request by the patient or by such patient's attending physician upon the request of the patient.

5. The sale, procurement, or issue of any professional malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the insured does or does not take or participate in any action under this article.

§ 2899-o. Safe disposal of unused medications. A person who has custody or control of any unused medication prescribed under this article after the death of the qualified individual shall personally deliver the unused medication for disposal to the nearest qualified facility that properly disposes of controlled substances or shall dispose of it by lawful means in accordance with regulations made by the commissioner, regulations made by or guidelines of the commissioner of education, or guidelines of a federal drug enforcement administration approved take-back program. A qualified facility that properly disposes of controlled substances shall accept and dispose of any medication delivered to it as provided hereunder regardless of whether such medication is a controlled substance. The commissioner may make regulations as may be appropriate for the safe disposal of unused medications prescribed, dispensed or ordered under this article as provided in this section.

§ 2899-p. Death certificate. 1. If otherwise authorized by law, the attending physician may sign the qualified individual's death certificate.

2. The cause of death listed on a qualified individual's death certificate who dies after self-administering medication under this article will be the underlying terminal illness or condition.

§ 2899-q. Reporting. 1. The commissioner shall annually review a sample of the records maintained under sections twenty-eight hundred ninety-nine-j and twenty-eight hundred ninety-nine-p of this article. The commissioner shall adopt regulations establishing reporting requirements for physicians taking action under this article to determine utilization and compliance with this article. The information collected under this subdivision shall not constitute a public record available for public inspection and shall be confidential and collected and maintained in a manner that protects the privacy of the patient, the patient's family, and any health care provider acting in connection with such patient under this article, except that such information may be disclosed to a governmental agency as authorized or required by law relating to professional discipline, protection of public health or law enforcement.

2. The commissioner shall prepare a report annually containing relevant data regarding utilization and compliance with this article and shall send such report to the legislature, and post such report on the department's website.

§ 2899-r. Penalties. 1. Nothing in this article shall be construed to limit professional discipline or civil liability resulting from conduct in violation of this article, negligent conduct, or intentional misconduct by any person.

2. Conduct in violation of this article shall be subject to applicable criminal liability under state law, including, where appropriate and without limitation, offenses constituting homicide, forgery, coercion, and related offenses, or federal law.

§ 2899-s. Severability. If any provision of this article or any application of any provision of this article, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that

shall not affect the validity or effectiveness of any other provision of this article, or of any other application of any provision of this article, which can be given effect without that provision or application; and to that end, the provisions and applications of this article are severable.

ARTICLE 29

HOSPITAL SURVEY, PLANNING AND REVIEW

- Section 2901. General powers and duties.
2902. Receipt and disbursement of funds.
2903. Designation as agency to administer federal hospital program in New York.
2904. State hospital review and planning council.
- 2904-a. Contracts between the commissioner of health and health systems agencies.
- 2904-b. Health systems agencies.
- 2904-c. Regional nominating committees.
2905. Cooperation of other departments and agencies.
2906. Hospitals included.
2907. Review of hospital operations.

§ 2901. General powers and duties. The department of health is generally authorized and empowered (a) to inventory existing hospitals of every character in the state, to survey the need for construction of hospitals and to develop programs for construction of such public or other nonprofit hospitals as will afford, in conjunction with existing facilities, the necessary physical facilities for furnishing adequate hospital services to all the people; and (b) to carry out the plan for construction of public and nonprofit hospitals and related facilities in accordance with such program.

The department of health shall also (a) keep records of all its activities; (b) prepare and maintain current progress information on development programs, hospital construction and current hospital facilities; (c) maintain liaison with federal officials and agencies

concerning hospitals and hospital planning; (d) have all other powers necessary to carry out any state plan adopted in conformity with the provisions of federal law relating thereto and, to effectuate the provisions of this section, take all necessary steps to conform to the requirements of the federal law concerning inventory, survey, planning and construction of hospitals; (e) establish rules and regulations relating to the administration of the provisions of this section.

The department of health shall also establish rules and regulations with regard to hearings which it must allow to every construction applicant who may be dissatisfied with action on its application.

§ 2902. Receipt and disbursement of funds. The department of taxation and finance is authorized to accept and receive from the federal government any moneys which the federal government shall offer to the state to assist it to inventory its hospitals, to survey the need of construction of hospitals, to develop a program for construction of public and nonprofit hospitals and to carry out the plan for construction of such hospitals in accordance with such program, and generally for all the purposes for which any such moneys shall be offered under or pursuant to any federal law heretofore or hereafter enacted authorizing grants to the state for such purposes or similar purposes, including payments to political subdivisions or any public or other nonprofit agencies of the state.

Any and all such grants and moneys awarded for assistance to this state under or pursuant to any federal law shall be accepted and received by the department of taxation and finance as custodian thereof and such moneys, so received, shall be deposited by such department of taxation and finance in a special fund or funds and shall be used exclusively for the purposes of any such federal law. Such moneys shall be paid from such fund or funds on the audit and warrant of the comptroller upon vouchers certified or approved by the commissioner.

Any moneys appropriated or otherwise available to the department of health may be disbursed by it to any political subdivision or voluntary

nonprofit agency or, on the advice of the state hospital review and planning council, to any health systems agency, pursuant to contract for services rendered to effectuate the purposes of this article.

§ 2903. Designation as agency to administer federal hospital program in New York. The department of health is hereby designated, and empowered to act, as the sole agency of the state, to carry out the purposes of any such federal law or laws heretofore or hereafter enacted. Such department is authorized to submit an inventory and survey in accordance with federal law, containing all information required by the surgeon general and a state plan providing for construction of adequate hospital facilities for the people residing within the state, regardless of their ability to pay therefor, without discrimination on account of race, creed or color, as may be required by such federal law or laws relating thereto, and to administer or supervise the administration of any plan or plans or otherwise act thereunder.

Application for funds, authorized to be received and accepted by the department of taxation and finance under section twenty-nine hundred two of this article, shall be made by the department of health to the surgeon general of the United States public health service or other appropriate agency.

§ 2904. State hospital review and planning council. (c) The governor shall approve each health systems agency with a defined geographical boundary, which shall consist of areas entirely within New York state except in those areas where a bi-state planning agreement exists. Such an agreement, subject to regulations promulgated by the commissioner of health, shall include but need not be limited to the following provisions: standards for equitable representation of board membership from each state; boundaries that are consistent with medical trade patterns; provisions for financial support from each state; and comparable policies and procedures to be implemented by the bi-state health systems agency in evaluating the availability and need for hospital or other health care facilities or services and governing the

collection of data and statistics for health planning. Any such bi-state agreement shall be signed by the governor of each state or their designee or the state's commissioner or secretary of health or their designee. The governor shall also adopt standards for the approval of all health systems agencies. The standards shall also include the applicable requirements of any other state or federal law. The charter or by-laws of every health systems agency must meet such standards. Failure to meet the standards or failure thereafter to maintain such standards shall result in the automatic withdrawal of the approval given to the health systems agency.

(d) To the maximum extent feasible, the boundaries of the health service areas established by the governor shall be appropriately coordinated with the boundaries of professional standards review organizations, existing regional planning areas, and state planning and administrative areas.

(g) Any health systems agency, with respect to any of the matters with which it may deal may hold such public hearings as it may deem appropriate and may require the submission of such information and documents as it may deem appropriate.

(h) The members of any health systems agency shall receive no compensation for their services but shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

(i) No civil action shall be brought in any court against any member, officer or employee of the state council or of any health systems agency for any act done, failure to act, or statement or opinion made, while discharging his duties as a member, officer or employee of the state council or agency, without leave from a justice of the supreme court, first had and obtained. In any event such member, officer or employee shall not be liable for damages in any such action if he shall have acted in good faith, with reasonable care and upon probable cause.

* (j) The council may employ either directly or by contractual arrangement such personnel necessary for the performance of its functions and to assist it in rendering independent judgment.

* NB Expired January 1, 1986

*** § 2904-a. Contracts between the commissioner of health and health**

systems agencies. 1. The commissioner of health is authorized to contract with a health systems agency to the extent of any appropriation therefor for such health systems agency to provide assistance to the state in implementing state health planning and development functions and priorities.

2. Any such contracts shall be for a period of no more than one year and shall include a provision providing for termination of the contract on notice by either party.

3. No health systems agency shall receive more than the sum of fifty thousand dollars annually, or so much thereof as is necessary, to effectuate the purposes of this section.

4. The commissioner of health shall submit a written report to the legislature no later than the first day of March, nineteen hundred eighty-two as to the number of such contracts entered into, the support to the state provided by the health systems agencies under such contracts and an assessment of the program.

* NB Expired September 30, 1982

§ 2904-b. Health systems agencies. 1. For the purposes of this section, "health systems agency" shall mean a corporation organized pursuant to the not-for-profit corporation law which is approved by the governor pursuant to subdivision (c) of section twenty-nine hundred four of this article, incorporated within the state, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development activities and functions.

2. The powers of a health systems agency shall include those necessary to perform the duties and functions provided for in this section.

3. An employee who participates in the management of a health benefit plan may serve as a member of the board of directors of a health systems agency representing employers or unions. No member may participate or

vote in agency proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a financial interest in the outcome of the board's proceedings other than as an individual consumer of health care services.

4. Each such health systems agency shall consist of a fixed number of members as determined by the health systems agency upon recommendation of the regional nominating committee established pursuant to section twenty-nine hundred four-c of this article to be necessary to appropriately represent the diverse needs and concerns of the region. The regional nominating committee shall approve a board of directors of such health systems agency in accordance with section two thousand nine hundred four-c of this article that is broadly representative of the region served by the agency and that meets the following requirements:

(a) A majority of the members, but not more than sixty percent of the members, shall be residents of the health service region served by the agency who are consumers of health care and major purchasers of health care, including labor organizations and business corporations, in the region. A consumer shall mean a person who is not a provider of health care as defined in accordance with paragraph (c) of this subdivision.

(b) The remainder of the members shall be residents of or have their principal place of business in the health service region served by the agency who are providers of health care and who, to the extent practicable, are representative of the variety of disciplines and interests of the health care system including (i) physicians, dentists, nurse practitioners, nurses, optometrists, podiatrists, physician's assistants, and other health professionals; (ii) health facilities including hospitals; (iii) health care insurers; (iv) health maintenance organizations; (v) health professional schools; (vi) the allied health professions; and (vii) other providers of health care. Not less than one-half of the providers of health care of the governing body of a health systems agency shall be direct providers of health care and of such direct providers of health care, at least one shall be a person engaged in the administration of a health facility.

(c) A "provider of health care" means an individual (i) who is a direct provider of health care or who is a representative of different disciplines, professions or sectors of health care providers and whose

primary current activity is the provision of health care to individuals or the administration (including trustees or members of boards of directors) of health facilities in which such care is provided; or (ii) who holds a fiduciary position with, or has a fiduciary interest in, any entity which has as its primary purpose the delivery of health care, the conduct of research into or instruction for health professionals in the provision of health care, or the production of or supply of drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provisions of health care; or (iii) who is a professional in the provision of health care, or the production of or supply of drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care; or (iv) who is a professional employee of a health professions school; or (v) who is a spouse of an individual described in subparagraph (i), (ii), (iii) or (iv) of this paragraph.

(d) Any individual may nominate another individual for consideration by the health systems agency for appointment to the board of directors of the respective agency. Such nominee shall reside or have their principal place of business within the respective health service region. In considering an individual for appointment to such agency, the agency shall, to the extent practicable, submit to the regional nominating committee prospective members which are representative of local government, local health care providers, payors, consumers of health care, members of labor organizations and business corporations.

5. (a) Members of the agency appointed on or after January first, nineteen hundred ninety-four shall have fixed terms of five years. No persons appointed on or after January first, nineteen hundred ninety-four shall be a member of an agency for more than ten years in any period of fifteen consecutive years including periods prior to January first, nineteen hundred ninety-four. A person appointed to fill a membership vacancy on an agency shall be representative of that membership category. The commissioner, in consultation with the health systems agencies, shall devise an equitable method of converting to these membership term requirements so that all such agencies shall be in compliance by December thirty-first, nineteen hundred ninety-six.

(b) A board member shall hold over and continue to discharge the

duties of his position after the expiration of the term for which such board member shall have been appointed until a successor shall be chosen and qualified; but after the expiration of such term, the position shall be deemed vacant for the purpose of choosing a successor. An appointment for a term shortened by reason of a predecessor holding over shall be for the residue of the term only.

6. A health systems agency may establish standing committees, subcommittees, and advisory committees as deemed necessary. To the extent practicable, all standing committees, subcommittees, and advisory groups appointed by the health systems agency shall be appointed in such manner as to provide broad representation in such a manner that a majority of the members shall be consumers of health care.

7. Each health systems agency shall:

(a) recommend to the appropriate authority approval or disapproval of applications for the establishment or construction of a hospital, the certification of home health agencies, and the authorization to provide a long-term home health care program; provided, however, that any such studies or activities conducted by the agency preparatory to such approval or disapproval shall not include any such study or activity regarding financial feasibility, character or competence, or architectural and technical analysis;

(b) assist appropriate state agencies in the development of standards and guidelines to determine public need for hospital and other health services;

(c) serve as a community resource to actively promote increased public knowledge and responsibility regarding the availability and appropriate utilization of health care services;

(d) develop regional health plans and carry out facility and health services planning;

(e) identify in consultation with local providers, employers, payors, and consumers priorities for improving health care delivery in the region;

(f) promote cooperative ventures, networking, and other voluntary cooperative efforts to improve quality, efficiency, affordability, and access to health care services in the region, including the provision of

technical assistance to rural networks;

(g) perform special studies to identify health care needs and service requirements in the region;

(h) review and comment on community service plans;

(i) conduct community education for consumers, providers, payors and for the general public in the region;

(j) collect and maintain regional and other health care data to be made available to the public, researchers, providers and others for health care education and development in the region;

(k) assist in the development and implementation of regional and local health delivery system initiatives including global budgets, rural networks and health networks;

(l) make recommendations for improving health care status and identify gaps and needed health care services in the region;

(m) undertake other activities to promote the delivery of health care services in the region with the goal of improving affordability, quality, efficiency, and access to health care services;

(n) when requested by the commissioner or otherwise required by law or regulation, provide recommendations to the commissioner regarding the awarding of grants for health services in the region;

(o) coordinate its activities with other appropriate general or special purpose regional health and human services planning or administrative agencies including area agencies on aging, local and regional alcohol abuse, drug abuse and mental health planning agencies, social services agencies, county public health departments, and local health officers. The health systems agency shall, as appropriate, obtain data from other agencies for use in planning and development activities, enter into agreements with other such agencies, and to the extent practicable, provide technical assistance to such other agencies;

(p) submit a semi-annual report to the senate and assembly health committees detailing the activities of each agency during that reporting period;

(q) annually submit a copy of its operating budget to the chairman of the senate finance committee and the chairman of the assembly ways and means committee and the director of the division of the budget. Such operating budget shall contain information detailing contributions received and the types and sources of contributions eligible for

matching grants;

(r) not permit local contributions from organizations or individuals, including but not limited to, a health care provider subject to the provisions of article twenty-eight, thirty-six or forty-four of this chapter, who are subject to review by the health systems agencies provided, however, that this prohibition shall not apply to local governments or to associations representing health care providers as described herein;

(s) through its board of directors adopt rules governing the agency's ability to sell resources and engage in fee for service activities or other contractual arrangements. No health systems agency shall engage in any fee for service activity with a provider or potential provider of health care services except local government without prior approval of the state hospital review and planning council. Such approval shall be issued or denied in a timely manner;

(t) perform any other duties and functions of the health systems agency required by law; and

(u) meet as often as necessary to carry out their functions pursuant to this section.

8. Each health systems agency may hire an executive director. The executive director may hire employees and consultants as authorized by the agency and may prescribe their duties.

9. The commissioner upon request of the health systems agencies may provide technical assistance to the agency for the duties and activities prescribed herein.

10. The governor shall withdraw approval given to health systems agencies for failure to comply with such requirements or failure thereafter to comply with such requirements.

11. The commissioner may promulgate such rules and regulations including performance criteria as necessary to carry out the purposes of this article.

12. The commissioner shall promulgate rules and regulations regarding

conflicts of interest and records of the health systems agencies.

*** § 2904-c. Regional nominating committees.** 1. There are hereby created eight regional nominating committees. The eight regional nominating committees shall operate within defined geographic boundaries consistent with the eight health systems agencies established pursuant to section two thousand nine hundred four-b of this article.

2. Each nominating committee shall consist of eleven members who shall be residents of each respective region and who have demonstrated an interest in regional health affairs. The members shall be appointed as follows: five shall be appointed by the governor; two by the temporary president of the senate; two by the speaker of the assembly; one by the minority leader of the senate; and one by the minority leader of the assembly. Two of the members initially appointed by the governor, shall each serve an initial term ending December thirty-first, nineteen hundred ninety-eight. One of the members initially appointed by the temporary president of the senate and one of the members initially appointed by the speaker of the assembly shall each serve for an initial term ending December thirty-first, nineteen hundred ninety-eight. The seven remaining members, shall each serve an initial term ending December thirty-first, nineteen hundred ninety-nine.

3. The members shall designate one of their number to serve as chair for a period of two years or until his term of office expires, whichever period is shorter. A vacancy occurring for any reasons other than by expiration of term shall be filled by the appointing officer for the remainder of the unexpired term. Six members of a committee shall constitute a quorum.

4. A regional nominating committee shall approve members of the board of directors to the health systems agency as submitted by such health systems agency pursuant to section twenty-nine hundred four-b of this article as members' terms expire or vacancies occur on or after January first, nineteen hundred ninety-four. Approval for membership on the board of directors of such agency shall require the concurrence of six

members of a committee. Nominations submitted by the health systems agencies to such nominating committee and subsequent approvals of such nominations to the health systems agencies shall be released to the public by the committee at the time of such submission or approval. A regional nominating committee shall take no longer than forty-five days to approve or disapprove agency board of director nominations. Such approval shall be in writing, and shall include the findings of the committee relating to the experience and aptitude for the agency position of each candidate. The committee shall notify the governor, the temporary president of the senate, and the speaker of the assembly and the commissioner concerning all approvals to the agencies including the aptitude and experience of the agency members.

5. Health systems agencies shall provide administrative support to the respective regional nominating committee.

6. The committee shall undertake such other activities as are necessary to carry out their functions pursuant to this article.

* NB Expired June 30, 1996

§ 2905. Cooperation of other departments and agencies. The department of health may request and shall receive from any department, division, board, bureau, commission or agency of the state or of any political subdivision thereof, such assistance and data as will enable it to properly carry out its activities and effectuate the purposes hereunder.

§ 2906. Hospitals included. As used in this article, the term "hospital" shall include public health centers, diagnostic or treatment centers, rehabilitation facilities, nursing homes and chronic disease hospitals as defined in section six hundred thirty-one (i) of the federal public health service act, as amended, tuberculosis, mental, chronic disease, and other types of hospitals, including laboratories, out-patient departments, nurses' homes and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care.

§ 2907. Review of hospital operations. The department shall continue to exercise all of the functions, powers and duties prescribed by this chapter in connection with hospital operations within the state with the objective of promoting the highest quality of hospital care for the citizens of the state.

ARTICLE 29-A

ACCESS TO COMMUNITY HEALTH CARE SERVICES IN RURAL AREAS

TITLE I

RURAL HEALTH CARE ACCESS

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TITLE 1-A

RURAL DENTISTRY PILOT PROGRAM

Section 2958-a. Rural dentistry pilot program.

TITLE I

RURAL HEALTH CARE ACCESS

Section 2950. Legislative findings.

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2957. Designation of primary care hospitals.

2958. Rural health care access development program.

§ 2950. Legislative findings. The legislature finds and determines as follows:

1. The health care delivery system is undergoing a major transformation in response to changing demographics and consumer needs, changes in reimbursement policies, the emergence of alternate service providers, and public pressure to control health care costs.

2. Such changes have a particularly severe impact on rural health care delivery, which consists of small, frequently isolated providers who have limited financial resources and health support networks. Many such providers are experiencing financial stress or certain barriers to change which could seriously reduce access to quality health care services by individuals in rural environs.

3. This development calls for greater sharing of information and resources among rural health care providers. The promotion of proper planning and cooperative efforts among such providers would improve individual access to health care in rural areas and enhance cost-effectiveness in the delivery of such services as tertiary, acute, primary, home health and skilled nursing care; and illness prevention.

4. It is, therefore, the intent of the legislature to encourage continued access to high quality health care in rural areas as well as the development of rural health network agreements among providers of health care servicing rural areas which result in the merger or integration and coordination of health care services pursuant to such network agreements; and to provide the necessary funding for such networks.

5. It is further the intent of the legislature that as needed, regulatory waivers may be granted to participating providers as required to successfully implement networks within the limits of prudent provision for the health, safety, and general welfare of the people receiving health care. In addition, the commissioner shall actively provide for technical assistance in order to support the creation and

operation of rural health networks.

6. It is further the intent of the legislature that, in order to promote access to health care services, to increase the required linkage of health care service providers, and promote the quality and continuity of care provided to residents in rural areas, it shall be the policy of this state to encourage cooperative, collaborative and integrative arrangements between rural networks and health care providers who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements might be anti-competitive within the meaning and intent of the federal antitrust laws, it is further the intent of the legislature to supplant competition with such arrangements to the extent necessary to accomplish the purposes of this article, and provide state action immunity under the federal antitrust laws with respect to the planning, implementation and operation of rural health networks and central services facility rural health networks and health care providers participating in or members of such networks.

§ 2951. Definitions. For the purposes of this article:

1. "Rural area" shall mean any county with less than two hundred thousand population or any town which has a population of less than two hundred persons per square mile or, if approved by the commissioner, any town which has a population of less than two hundred fifty persons per square mile.

2. "Rural health network" shall mean an affiliation of health care providers serving a rural area, pursuant to a contract, joint or cooperative agreement, or organized pursuant to the not-for-profit corporation law and approved pursuant to subdivision fourteen of section twenty-eight hundred one-a of this chapter, which provides or arranges for the provision of health care services pursuant to a network plan to residents of a rural area or the provision of administrative or management services among such health care providers. Such health care services may include, but need not be limited to: acute and tertiary care; medical/surgical care; pre-hospital emergency services; swing bed care; mental health and substance abuse services; physical medicine and

rehabilitation; primary and preventive care; home health and skilled nursing care; laboratory, radiological or other diagnostic services; hospice; respite care; illness prevention; or any other outpatient or related services responding to community need or for the purpose of improving community health status. Such administrative and management services may include, but need not be limited to: emergency medical services or other professional training; credentialing, payroll, purchasing and billing services; recruitment of qualified professionals; information management services; medical transportation; quality assurance; risk management; peer review; electronic data sharing; and managed care systems; performance of studies; planning; and solicitation and acceptance of grants, and receipt of reimbursement for planning and coordination of services and coordination of experimental and other payment methods, such as global budget, pooling arrangements, or capitation payments for inpatient hospital services and ambulatory care services provided by the component entities of the network.

3. "Network plan" shall mean a written plan prepared by a rural health network or rural providers planning to form a rural health network, with the involvement of consumers, submitted initially and updated periodically as needed, to the commissioner for approval to receive grant funds pursuant to section twenty-nine hundred fifty-two of this article.

4. "Upgraded diagnostic and treatment center" shall mean a diagnostic and treatment center established pursuant to article twenty-eight of this chapter which has received such designation pursuant to section twenty-nine hundred fifty-six of this article.

§ 2952. Rural health network development grant program. To the extent of funds available therefor, the sum of seven million dollars shall annually be available for periods prior to January first, two thousand three, and up to six million five hundred thirty thousand dollars annually for the period January first, two thousand three through December thirty-first, two thousand four, up to seven million sixty-two thousand dollars for the period January first, two thousand five through

December thirty-first, two thousand six annually, up to seven million sixty-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to one million seven hundred sixty-six thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and within amounts appropriated for each state fiscal year on and after April first, two thousand eleven, shall be available to the commissioner from funds made available pursuant to section twenty-eight hundred seven-l of this chapter for grants pursuant to this section. 1. The commissioner shall establish a rural health network development grant program for the purpose of assisting community based health care providers, consumers and organizations in rural areas to promote more effective health care delivery through the coordination, development, planning, implementation and operation of rural health networks pursuant to this title. Such grants shall support activities and organizational costs including, but not limited to, the recruitment of qualified health care professionals, the performance of feasibility studies, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community based primary care systems, the integration and expansion of prehospital emergency medical services and related consulting and legal fees.

2. To be eligible to receive grant funding pursuant to this section, the applicant shall submit a network plan to the commissioner for approval; the network plan shall identify network participants and indicate how the members or participants of the rural health network intend to respond to the health care needs of the rural area, improve access to and the quality of care for residents of the community, promote the coordination of resources among providers and reduce duplication of services while achieving cost and other operational efficiencies.

3. a. The commissioner shall make grants to rural health networks, or rural health care providers planning to develop a rural health network. The network plan submitted by a rural health network or rural health care providers planning to form a network for grant funds pursuant to

this section shall be consistent with guidelines issued by the commissioner, in consultation with the New York state rural health council and the legislative commission on the development of rural resources. Such guidelines shall include, but need not be limited to, the duration of rural health network grants, appropriate funding levels and criteria for providing an appropriate geographic distribution of grantees; provided, however, that the amount of any such grant shall be based on the scope and nature of the proposed activities described in such plan and that the quality of any such plan complies with the conditions for approval pursuant to paragraph b of subdivision three of this section.

b. The commissioner may require revisions or amendments to the initial network plan prior to approval for funding, or periodic updates from an applicant to reflect the current status of a network's development or operation and to assure that the plan is implemented in accordance with its approved terms. In approving grants the commissioner shall consider the following:

(i) The specific objectives and description of the proposed network, including considerations of the existing health care services currently being delivered within the rural area, and the unmet health care needs of the community;

(ii) The degrees to which the plan demonstrates enhanced costs and service delivery efficiencies and access to necessary and high quality health care services by rural residents;

(iii) The degree to which stated objectives and the scope of the network plan may reasonably be implemented and achieved using existing and projected resources;

(iv) The degree to which information sharing, communication, and cooperation between health care providers, human service entities and consumers would be fostered;

(v) The contribution the network would make toward the identification and development of innovative delivery systems;

(vi) The degree to which management and continuity of care would be fostered and improved;

(vii) The degree to which participating providers are represented on governing bodies of the network;

(viii) The degree to which consumers within the area served or to be served by the network are made aware of and have an effective opportunity to provide input in the creation and on-going development of a network plan; and

(ix) The degree to which providers within the area served by the network are made aware of and have an effective opportunity to participate in or become a member of the network.

c. The commissioner shall act on such application within ninety days after its receipt. In the event waivers of any regulations are requested by an applicant, the commissioner shall have an additional thirty days to act upon such application.

4. The commissioner or his or her duly authorized representative may provide or contract to provide technical assistance in the creation and implementation of rural health networks and to promote community organization, collaboration and communication in rural network development across the state. The funding for any such contract shall not be made available from funds provided for purposes of this section by section twenty-eight hundred seven-1 of this chapter.

5. If the commissioner determines that a grant is being used for purposes other than those which are in conformity with this title, the commissioner may withdraw his or her approval of the project and require repayment of all or part of such grant to the state. The commissioner shall cause reports to be prepared and submitted for each project by the grantees at such times and in such manner as are consistent with the purposes of this title.

6. a. The commissioner or his or her duly authorized representative may also, promote appropriate active state supervision necessary to promote state action immunity under the federal antitrust laws, inspect or request additional documentation to verify that a network plan is implemented in accordance with its approved terms as they relate to antitrust activity.

b. The commissioner shall review a network plan and all agreements

between participating providers of a network organized pursuant to the not-for-profit corporation law at any time with respect to their effect on competition, access, and quality of care, may seek the advice of the attorney general and may require amendments to such agreements where he or she determines that the benefits of anti-competitive activity are outweighed by any disadvantages.

c. The commissioner may revoke, limit or annul approval to implement a network plan, or portions thereof, after review and a hearing, for failure to implement such plan in accordance with its terms as appropriate for the promotion of state action immunity under the federal antitrust laws.

d. The commissioner shall, at the request of any rural health network, review network agreements with respect to their effect on competition, access and quality of care, may seek the advice of the attorney general, and may require amendments to such agreements where he or she determines that the benefits of anticompetitive activity are outweighed by any disadvantage.

7. For the purpose of promoting maximum effectiveness in the utilization of state and local monies and innovative approaches, the commissioner is authorized to waive, modify or suspend the respective provisions of rules and regulations promulgated pursuant to this chapter if the commissioner determines that such waiver, modification or suspension is necessary for the successful implementation of this title and provided that the commissioner determines that the health, safety and general welfare of people receiving health care will not be impaired as a result of such waiver, modification, or suspension. Such waiver, modification or suspension may be granted for up to two years. In addition, upon the request of a rural health network organized pursuant to the not-for-profit corporation law and approved pursuant to subdivision fourteen of section twenty-eight hundred one-a of this chapter thereto, through its network plan or its amendments, the commissioner is authorized to permit such rural health network to make applications or fulfill regulatory requirements on behalf of members of the network for purposes of, but not limited to, certificate of need,

quality assurance, reimbursement, and professional credentialing and privileging.

8. The commissioner shall consult with federal, state, and local officials with respect to securing their cooperation in coordinating related programs and regulatory waivers and shall provide the legislature with recommendations to facilitate such efforts.

9. Notwithstanding any inconsistent provision of law, the commissioner may approve a rural health network, to receive directly reimbursement for the planning and coordination of services including but not limited to such experimental and other payment methods as global budget, pooling arrangements, or capitation payments for whole or in-part inpatient hospital services and ambulatory care services provided by the component entities of the network. Reimbursement including payments made by governmental agencies shall be subject to the approval of the state director of the budget and to the availability of federal financial participation pursuant to title XIX of the federal social security act in expenditures made for eligible patients. The commissioner may impose such terms and conditions as necessary and appropriate for receipt of such funds.

§ 2954. Limitation on liability of network participants. Neither a rural health network, nor any provider participating therein, whether by agreement or through membership or common directorates, shall be liable for claims against or for the debt or obligations of any other affiliate solely by reason of affiliation or, in the absence of substantial evidence of fraud or willful, wanton or criminal activity attributable to the incurring of such claim, debt or obligation on the part of the entity from whom recovery is sought.

§ 2955. Restraint of trade by networks and network participants. The activities of rural health networks and providers participating therein, undertaken in furtherance of planning, implementing or operating a network or promoting the efficient delivery of health care services in a

rural area, shall be exempt from the provisions and penalties of article twenty-two of the general business law respecting arrangements and agreements in restraint of trade. No hospital, physician or other licensed or certified health care provider operating in good standing, serving the area of the network, and willing to meet the terms and conditions of the network as defined in the network plan, shall be denied the ability to participate therein. Nothing contained herein shall be construed to require a hospital to grant admitting privileges to a physician solely because such physician is a participant in or a member of the network.

§ 2956. Designation of upgraded diagnostic and treatment centers. 1. A diagnostic and treatment center established pursuant to article twenty-eight of this chapter, which is a participant in or a member of a rural health network, may request the commissioner to authorize such diagnostic and treatment center to provide limited emergency services. Such diagnostic and treatment center shall be designated an upgraded diagnostic and treatment center upon the commissioner's approval of such request.

2. The commissioner shall establish guidelines for the designation of a diagnostic and treatment center as an upgraded diagnostic and treatment center pursuant to the provisions of this section. In establishing such guidelines, the commissioner shall solicit input from hospitals, diagnostic and treatment centers and physicians.

§ 2957. Designation of primary care hospitals. 1. A general hospital established pursuant to article twenty-eight of this chapter may request the commissioner to exempt such hospital from particular services or to authorize such hospital to offer additional special services. Such hospital shall be designated a primary care hospital upon the commissioner's approval of such request; provided, however, that nothing herein contained shall be construed to restrict such hospital from offering primary, specialty or acute inpatient services for which it is able to provide appropriate technical and human resources, to respond to

community need, or to assure quality in the delivery of services.

2. The commissioner shall establish guidelines for the designation of a general hospital as a primary care hospital pursuant to the provisions of this section. In establishing such guidelines, the commissioner shall solicit input from hospitals and physicians.

§ 2958. Rural health care access development program. 1. To the extent of funds available therefor, the sum of ten million dollars shall annually be made available for periods prior to January first, two thousand three, and up to nine million three hundred twenty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million three hundred twenty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million eighty-eight thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twelve million eighty-eight thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to eleven million eighty-eight thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to two million seven hundred seventy-two thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and within amounts appropriated for each state fiscal year on and after April first, two thousand eleven, shall be available to the commissioner from funds pursuant to section twenty-eight hundred seven-1 of this chapter to provide assistance to general hospitals classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, in recognition of the unique costs incurred by these facilities to provide hospital services in remote or sparsely populated areas pursuant to subdivision two of this section.

2. a. The commissioner shall provide assistance to all rural hospitals

as defined in this section by distributing all amounts made available pursuant to section twenty-eight hundred seven-1 of this chapter.

b. For the purposes of this subdivision, the commissioner shall devise a distribution methodology that takes into account the need for rural hospitals to improve operational efficiencies, reduce the duplication of services, and develop affiliations with community based health care providers and which recognizes whether a hospital is a federally designated sole community hospital, rural referral center, rural hospital, state designated rural hospital, or a hospital that is at substantial financial risk of failure and whose service area is threatened with reduced access to essential health services. In no event shall the size of the rural hospital be the sole contributing factor in such distribution methodology. Such methodology shall provide assistance at graduated levels from highest to lowest, in accordance with the following criteria:

(i) The hospital shall be at substantial risk of financial failure, using a combination of generally accepted standard measures of financial viability and which is:

A. a federally designated sole community hospital or a rural referral center and is both a federally designated rural hospital and is classified as a state rural hospital;

B. a federally designated sole community hospital or a rural referral center and is a federally designated rural hospital;

C. both a federally designated rural hospital and is classified as a state rural hospital, but is not a sole community hospital or a rural referral center;

D. either a federally designated rural hospital or is classified as a state rural hospital; or

E. the hospital is either a federally defined sole community hospital or rural referral center.

(ii) The hospital is a sole community hospital or a rural referral

center and is both a federally designated rural hospital and is classified as a state rural hospital;

(iii) The hospital is a sole community hospital or a rural referral center and is a federally designated rural hospital, but is not classified as a state rural hospital;

(iv) The hospital is both a federally designated rural hospital and is classified as a state rural hospital but is not a sole community hospital or a rural referral center;

(v) The hospital is either a federally designated rural hospital or is classified as a state rural hospital; or

(vi) The hospital is either a federally defined sole community hospital or a rural referral center.

c. The commissioner may include in regulation a factor to enhance the distribution to those hospitals that have taken actions in accordance with the goals specified in paragraph b of this subdivision to be applied effective January first, two thousand one, except, however, in no event shall the distribution of the funds be delayed because of the development of the factor pursuant to this paragraph.

3. The commissioner shall cause reports to be prepared and submitted by rural hospitals at such times and in such manner as are consistent with the purposes of this section.

TITLE 1-A

RURAL DENTISTRY PILOT PROGRAM

Section 2958-a. Rural dentistry pilot program.

§ 2958-a. Rural dentistry pilot program. 1. The commissioner shall, within monies appropriated therefore, establish a rural dentistry pilot program in Chautauqua, Allegany, and Cattaraugus counties. The commissioner shall, in coordination with the University of Buffalo School of Dentistry study cost savings achieved through the provision of dental services in geographically isolated and underserved areas. Such a study shall determine:

- (i) the quality of care provided through a mobile dental system, including minimizing any adverse effects on dental practices already serving or seeking to enter rural or underserved communities, the involvement of dental practices serving rural or underserved communities in such a mobile dental system, and the establishment of referral systems and networks to existing dental practices serving rural or underserved communities for regular ongoing care of patients;
- (ii) cost savings achieved through targeted oral health initiatives in rural areas;
- (iii) corollaries between preventative dental care and improved patient outcomes in rural areas;
- (iv) knowledge, attitude, and behavior outcomes among dental students and recommendations for rural dental health education curriculum;
- (v) a profile of the participants, the number of persons served, and health care disparities;
- (vi) a description of the activities of the program;
- (vii) guidance on facilitated participation in rural areas;
- (viii) provider shortages in rural areas;
- (ix) a description of the impact of the programs on the community and recommendations for replication/improvement in other rural areas; and
- (x) such other activities as the commissioner may deem necessary and appropriate to this section.

2. Twelve months after the approval of the rural dentistry pilot program, and annually thereafter, the program shall report to the commissioner on the progress of the program. The commissioner shall evaluate the findings of the study and report to the governor, the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on health, the chair of the assembly health committee and the chair of the legislative commission on rural resources on its findings.

3. Additionally, to the extent of funds appropriated therefore, medical assistance funds, including any funding or shared savings as may become available through federal waivers or otherwise under titles eighteen and nineteen of the federal social security act, may be used for expenditures in support of the demonstration program.

4. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is authorized to waive, modify or suspend the provisions of rules and regulations promulgated pursuant to article twenty-eight of this chapter if the commissioner determines that such waiver, modification or suspension is necessary for the successful implementing of the rural dentistry pilot program authorized pursuant to this section and provided that the commissioner determines that the health, safety and general welfare of people receiving health care under such rural dentistry pilot program will not be impaired as a result of such waiver, modification, or suspension.

ARTICLE 29-AA

PATIENT CENTERED MEDICAL HOMES

Section 2959-a. Multipayor patient centered medical home program.

§ 2959-a. Multipayor patient centered medical home program. 1. (a) The commissioner is authorized to establish medical home multipayor programs (referred to in this section as a "program") whereby enhanced payments are made to primary care clinicians and clinics statewide that are certified as medical homes for the purpose of improving health care outcomes and efficiency through improved access, patient care continuity and coordination of health services.

(b) As used in this section:

(i) "clinic" means a general hospital providing outpatient care or diagnostic and treatment center, licensed under article twenty-eight of this chapter; and

(ii) "primary care clinician" means a physician, nurse practitioner, or midwife acting within his or her lawful scope of practice under title eight of the education law and who is practicing in a primary care specialty.

(iii) "primary care medical home collaborative" means an entity approved by the commissioner which shall include but not be limited to health care providers, which may include but not be limited to hospitals, diagnostic and treatment centers, private practices and

independent practice associations, and payors of health care services, which may include but not be limited to employers, health plans and insurers.

2. (a) In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among payors of health care services and health care services providers who might otherwise be competitors, under the active supervision of the commissioner. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws to payors of health care services and health care services providers with respect to the planning, implementation and operation of the multipayor patient centered medical home program.

(b) The commissioner or his or her duly authorized representative may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation from payors of health care services and health care services providers to verify that medical homes certified pursuant to this section operate in accordance with its intent and purpose.

3. The commissioner is authorized to participate in, actively supervise, facilitate and approve a primary care medical home collaborative for each program around the state to establish: (a) the boundaries of each program and the providers eligible to participate, provided that the boundaries of programs may overlap; (b) practice standards for each medical home program adopted with consideration of existing standards developed by the National Committee for Quality Assurance ("NCQA"), the Joint Commission of Accreditation of Healthcare Organizations ("JCAHCO" or the "Joint Commission"), American Accreditation Healthcare Commission ("URAC"), American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association; the American Academy of Nurse Practitioners, and the American College of

Nurse Practitioners; (c) standards for implementation and use of health information technology, including participation in health information exchanges through the statewide health information network; (d) methodologies by which payors will provide enhanced rates of payment to certified medical homes; (e) requirements for collecting data relating to the providing and paying for health care services under the program and providing of data to the commissioner, payors and health care providers under the program, to promote the effective operation and evaluation of the program, consistent with protection of the confidentiality of individual patient information; and (f) provisions under which the commissioner may terminate the program.

3-a. The commissioner may develop or approve (a) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards established by each multipayer patient centered medical home collaborative; (b) alternative methodologies for payors of health care services to health care providers under the program; (c) provisions for payments to providers that may vary by size or form of organization of the provider, or patient case mix, to accommodate different levels of resources and difficulty to meet the standards of the program; (d) provisions for payments to entities that provide services to health care providers to assist them in meeting medical home standards under the program such as the services of community health workers.

4. The commissioner is authorized to establish an advisory group of state agencies and stakeholders, such as professional organizations and associations, and consumers, to identify legal and/or administrative barriers to the sharing of care management and care coordination services among participating health care services providers and to make recommendations for statutory and/or regulatory changes to address such barriers.

5. Patient, payor and health care services provider participation in the multipayer patient centered medical home program shall be on a voluntary basis.

6. Clinics and primary care clinicians participating in a program are not eligible for additional enhancements or bonuses under the statewide patient centered medical home program established pursuant to section three hundred sixty-four-m of the social services law. The commissioner shall develop or approve a method for determining payment under a program where a provider participates, or a patient is served, in an area where program boundaries overlap.

7. Subject to the availability of funding and federal financial participation, the commissioner is authorized:

(a) To pay enhanced rates of payment under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus to clinics and clinicians that are certified as patient centered medical homes under this title;

(b) To pay additional amounts for medical homes that meet specific process or outcome standards specified by the commissioner in consultation with each multipayer patient centered medical home collaborative;

(c) To authorize alternative payment methodologies under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus for health care providers and to serve the purposes of the program, including payments to entities under paragraph (g) of subdivision three of this section; and

(d) To test new models of payment to high volume Medicaid primary care medical home practices that incorporate risk adjusted global payments combined with care management and pay for performance adjustments.

8. (a) The commissioner is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the health home provisions of section three hundred sixty-five-l of the social services law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data

collection; data sharing; program evaluation, and preparation of reports.

(b) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a request for proposal process, provided, however, that:

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

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

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

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

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

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

(iii) The commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

9. The commissioner may directly, or by contract, provide:

(a) technical assistance to a primary care medical home collaborative in relation to establishing and operating a program;

(b) consumer assistance to patients participating in a program as to matters relating to the program;

(c) technical and other assistance to health care providers participating in a program as to matters relating to the program, including achieving medical home standards;

(d) care coordination provider technical and other assistance to individuals and entities providing care coordination services to health care providers under a program; and

(e) information sharing and other assistance among programs to improve

the operation of programs, consistent with applicable laws relating to patient confidentiality.

10. The commissioner shall, to the extent necessary for the purpose of this section, submit the appropriate waivers and other applications, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers or applications necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under Medicaid, family health plus and child health plus or Medicare. Copies of such original waiver and other applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

11. The Adirondack medical home multipayor demonstration program (including the Adirondack medical home collaborative) previously established under section twenty-nine hundred fifty-nine of this chapter is continued and shall be deemed to be a program under this section.

ARTICLE 29-C

HEALTH CARE AGENTS AND PROXIES

Section 2980. Definitions.

2981. Appointment of health care agent; health care proxy.

2982. Rights and duties of agent.

2983. Determination of lack of capacity to make health care decisions for the purpose of empowering agent.

2984. Provider's obligations.

2985. Revocation.

2986. Immunity.

2987. Liability for health care costs.

2988. Requiring or prohibiting execution of proxy.

2989. Effect on other rights.

2990. Proxies executed in other states.

2991. Creation and use of proxies in residential health care and

- mental hygiene facilities.
- 2992. Special proceeding authorized.
- 2993. Regulations.
- 2994. Rights to be publicized.

§ 2980. Definitions. The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Adult" means any person who is eighteen years of age or older, or is the parent of a child, or has married.

2. "Attending practitioner" means the physician, physician assistant, or nurse practitioner, licensed or certified pursuant to title eight of the education law, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient. Where more than one physician, physician assistant, or nurse practitioner shares such responsibility, or where a physician, physician assistant, or nurse practitioner is acting on the attending practitioner's behalf, any such physician, nurse practitioner, or physician assistant may act as the attending practitioner pursuant to this article.

2-a. "Nurse practitioner" means a nurse practitioner certified under section sixty-nine hundred ten of the education law, practicing within his or her scope of practice.

2-b. "Psychiatric nurse practitioner" means a nurse practitioner certified by the department of education as a psychiatric nurse practitioner.

3. "Capacity to make health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.

4. "Health care" means any treatment, service or procedure to diagnose

or treat an individual's physical or mental condition.

5. "Health care agent" or "agent" means an adult to whom authority to make health care decisions is delegated under a health care proxy.

6. "Health care decision" means any decision to consent or refuse to consent to health care.

7. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

8. "Health care proxy" means a document delegating the authority to make health care decisions, executed in accordance with the requirements of this article.

9. "Hospital" means a general hospital as defined in subdivision ten of section two thousand eight hundred one of this chapter and a residential health care facility as defined in subdivision three of section two thousand eight hundred one of this chapter, and a mental hygiene facility as defined in subdivision ten of this section and a hospice as defined in subdivision one of section four thousand two of this chapter.

9-a. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending practitioner to a reasonable degree of medical certainty. For purposes of this article, cardiopulmonary resuscitation is presumed to be a life sustaining treatment without the necessity of a determination by an attending practitioner.

10. "Mental hygiene facility" means a residential facility, excluding family care homes, operated or licensed by the office of mental health or the office for people with developmental disabilities.

11. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, provided, however,

that mental illness shall not include dementia, such as alzheimer's disease or other disorders related to dementia.

12. "Principal" means a person who has executed a health care proxy.

13. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending practitioner or another person acting on behalf of the attending practitioner or the hospital.

14. "Residential health care facility" means a residential health care facility as defined in subdivision three of section two thousand eight hundred one of this chapter.

15. "Qualified psychiatrist" means, for the purposes of this article, a physician licensed to practice medicine in New York state who: (a) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that board; or (b) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

§ 2981. Appointment of health care agent; health care proxy. 1.

Authority to appoint agent; presumption of competence. (a) A competent adult may appoint a health care agent in accordance with the terms of this article.

(b) For the purposes of this section, every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent, or unless a guardian of the person has been appointed for the adult pursuant to article eighty-one of the mental hygiene law or article seventeen-A of the surrogate's court procedure act.

2. Health care proxy; execution; witnesses. (a) A competent adult may appoint a health care agent by a health care proxy, signed and dated by the adult in the presence of two adult witnesses who shall also sign the proxy. Another person may sign and date the health care proxy for the adult if the adult is unable to do so, at the adult's direction and in

the adult's presence, and in the presence of two adult witnesses who shall sign the proxy. The witnesses shall state that the principal appeared to execute the proxy willingly and free from duress. The person appointed as agent shall not act as witness to execution of the health care proxy.

(b) For persons who reside in a mental hygiene facility operated or licensed by the office of mental health, at least one witness shall be an individual who is not affiliated with the facility and, if the mental hygiene facility is also a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, at least one witness shall be a qualified psychiatrist or psychiatric nurse practitioner.

(c) For persons who reside in a mental hygiene facility operated or licensed by the office for people with developmental disabilities, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician, nurse practitioner, physician assistant or clinical psychologist who either is employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office for people with developmental disabilities, or has been approved by the commissioner of developmental disabilities in accordance with regulations approved by the commissioner. Such regulations shall require that a physician, nurse practitioner, physician assistant, or clinical psychologist possess specialized training or three years experience in treating developmental disabilities.

2-a. Alternate procedure for witnessing of health care proxies. Witnessing a health care proxy under this section may be done using audio-video technology, for either or both witnesses, provided that the following conditions are met (as used in this subdivision, "remote witness" means a witness acting using audio-visual technology):

(a) The principal, if not personally known to a remote witness, shall display valid photographic identification to the remote witness during the audio-video conference;

(b) The audio-video conference shall allow for direct interaction between the principal and any remote witness;

(c) Any remote witness shall receive a legible copy of the health care proxy, which shall be transmitted via facsimile or electronic means, within twenty-four hours of the proxy being signed by the principal during the audio-video conference; and

(d) The remote witness shall sign the transmitted copy of the proxy, and transmit it back to the principal.

3. Restrictions on who may be and limitations on a health care agent.

(a) An operator, administrator or employee of a hospital may not be appointed as a health care agent by any person who, at the time of the appointment, is a patient or resident of, or has applied for admission to, such hospital.

(b) The restriction in paragraph (a) of this subdivision shall not apply to:

(i) an operator, administrator or employee of a hospital who is related to the principal by blood, marriage or adoption; or

(ii) a physician, physician assistant, or nurse practitioner, subject to the limitation set forth in paragraph (c) of this subdivision, except that no physician or nurse practitioner affiliated with a mental hygiene facility or a psychiatric unit of a general hospital may serve as agent for a principal residing in or being treated by such facility or unit unless the physician is related to the principal by blood, marriage or adoption.

(c) If a physician, physician assistant, or nurse practitioner is appointed agent, the physician, physician assistant, or nurse practitioner shall not act as the patient's attending practitioner after the authority under the health care proxy commences, unless the physician, physician assistant, or nurse practitioner declines the appointment as agent at or before such time.

(d) No person who is not the spouse, child, parent, brother, sister or grandparent of the principal, or is the issue of, or married to, such person, shall be appointed as a health care agent if, at the time of appointment, he or she is presently appointed health care agent for ten principals.

4. Commencement of agent's authority. The agent's authority shall commence upon a determination, made pursuant to subdivision one of

section two thousand nine hundred eighty-three of this article, that the principal lacks capacity to make health care decisions.

5. Contents and form of health care proxy. (a) The health care proxy shall:

(i) identify the principal and agent; and

(ii) indicate that the principal intends the agent to have authority to make health care decisions on the principal's behalf.

(b) The health care proxy may include the principal's wishes or instructions about health care decisions, and limitations upon the agent's authority.

(c) The health care proxy may provide that it expires upon a specified date or upon the occurrence of a certain condition. If no such date or condition is set forth in the proxy, the proxy shall remain in effect until revoked. If, prior to the expiration of a proxy, the authority of the agent has commenced, the proxy shall not expire while the principal lacks capacity.

(d) A health care proxy may, but need not, be in the following form:

Health Care Proxy

I (name of principal) hereby appoint (name, home address and telephone number of agent) as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

NOTE: Although not necessary, and neither encouraged nor discouraged, you may wish to state instructions or wishes, and limit your agent's authority. Unless your agent knows your wishes about artificial nutrition and hydration, your agent will not have authority to decide about artificial nutrition and hydration. If you choose to state instructions, wishes, or limits, please do so below:

I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint (name, home address and telephone number of alternate agent) as my health care agent.

I understand that, unless I revoke it, this proxy will remain in effect indefinitely or until the date or occurrence of the condition I have stated below:

(Please complete the following if you do NOT want this health care proxy to be in effect indefinitely):

This proxy shall expire: (Specify date or condition)
Signature:

Address:

Date:

I declare that the person who signed or asked another to sign this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence and that person signed in my presence. I am not the person appointed as agent by this document.

Witness:

Address:

Witness:

Address:

(e) The health care proxy shall not be executed on a form or other writing that also includes the execution of a power of attorney, provided, however, that nothing in this paragraph shall invalidate a delegation of the authority to make health care decisions executed prior to the enactment of this article.

(f) A health care proxy may include the principal's wishes or instructions regarding organ and tissue donation and may limit the health care agent's authority to consent to organ or tissue donation or designate another person to do so, under article forty-three of this chapter. Failure to state wishes or instructions shall not be construed to imply a wish not to donate.

6. Alternate agent. (a) A competent adult may designate an alternate agent in the health care proxy to serve in place of the agent when:

(i) the attending practitioner has determined in a writing signed by the physician, physician assistant, or nurse practitioner (A) that the person appointed as agent is not reasonably available, willing and competent to serve as agent, and (B) that such person is not expected to become reasonably available, willing and competent to make a timely decision given the patient's medical circumstances;

(ii) the agent is disqualified from acting on the principal's behalf pursuant to subdivision three of this section or subdivision two of section two thousand nine hundred ninety-two of this article, or

(iii) under conditions set forth in the proxy.

(b) If, after an alternate agent's authority commences, the person appointed as agent becomes available, willing and competent to serve as agent:

(i) the authority of the alternate agent shall cease and the authority of the agent shall commence; and

(ii) the attending practitioner shall record the change in agent and the reasons therefor in the principal's medical record.

§ 2982. Rights and duties of agent. 1. Scope of authority. Subject to any express limitations in the health care proxy, an agent shall have the authority to make any and all health care decisions on the principal's behalf that the principal could make. Such authority shall be subject to the provisions of section twenty-nine hundred eighty-nine of this article.

2. Decision-making standard. After consultation with a licensed physician, registered nurse, physician assistant, nurse practitioner, licensed psychologist, licensed master social worker, or a licensed clinical social worker, the agent shall make health care decisions: (a) in accordance with the principal's wishes, including the principal's religious and moral beliefs; or (b) if the principal's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the principal's best interests; provided, however, that if the principal's wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures.

3. Right to receive information. Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical records necessary to make informed decisions regarding the principal's health care.

4. Priority over other surrogates. Health care decisions by an agent on a principal's behalf pursuant to this article shall have priority over decisions by any other person, except as otherwise provided in the health care proxy or in subdivision five of section two thousand nine hundred eighty-three of this article.

§ 2983. Determination of lack of capacity to make health care decisions for the purpose of empowering agent. 1. Determination by attending practitioner. (a) A determination that a principal lacks capacity to make health care decisions shall be made by the attending practitioner to a reasonable degree of medical certainty. The

determination shall be made in writing and shall contain such attending practitioner's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration. The determination shall be included in the patient's medical record. For a decision to withdraw or withhold life-sustaining treatment, the attending practitioner who makes the determination that a principal lacks capacity to make health care decisions must consult with another physician, physician assistant, or nurse practitioner to confirm such determination. Such consultation shall also be included within the patient's medical record.

(b) If an attending practitioner of a patient in a general hospital or mental hygiene facility determines that a patient lacks capacity because of mental illness, the attending practitioner who makes the determination must be, or must consult, for the purpose of confirming the determination, with a qualified psychiatrist. A record of such consultation shall be included in the patient's medical record.

(c) If the attending practitioner determines that a patient lacks capacity because of a developmental disability, the attending practitioner who makes the determination must be, or must consult, for the purpose of confirming the determination, with a physician, nurse practitioner, physician assistant, or clinical psychologist who either is employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law, or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office for people with developmental disabilities, or has been approved by the commissioner of developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician, nurse practitioner, physician assistant, or clinical psychologist possess specialized training or three years experience in treating developmental disabilities. A record of such consultation shall be included in the patient's medical record.

(d) A physician, physician assistant, or nurse practitioner who has been appointed as a patient's agent shall not make the determination of the patient's capacity to make health care decisions.

2. Request for a determination. If requested by the agent, an

attending practitioner shall make a determination regarding the principal's capacity to make health care decisions for the purposes of this article.

3. Notice of determination. Notice of a determination that a principal lacks capacity to make health care decisions shall promptly be given: (a) to the principal, orally and in writing, where there is any indication of the principal's ability to comprehend such notice; (b) to the agent; (c) if the principal is in or is transferred from a mental hygiene facility, to the facility director; and (d) to the guardian of the principal, if any.

4. Limited purpose of determination. A determination made pursuant to this section that a principal lacks capacity to make health care decisions shall not be construed as a finding that the patient lacks capacity for any other purpose.

5. Priority of principal's decision. Notwithstanding a determination pursuant to this section that the principal lacks capacity to make health care decisions, where a principal objects to the determination of incapacity or to a health care decision made by an agent, the principal's objection or decision shall prevail unless the principal is determined by a court of competent jurisdiction to lack capacity to make health care decisions.

6. Confirmation of lack of capacity. (a) The attending practitioner shall confirm the principal's continued incapacity before complying with an agent's health care decisions, other than those decisions made at or about the time of the initial determination made pursuant to subdivision one of this section. The confirmation shall be stated in writing and shall be included in the principal's medical record.

(b) The notice requirements set forth in subdivision three of this section shall not apply to the confirmation required by this subdivision.

7. Effect of recovery of capacity. In the event the attending practitioner determines that the principal has regained capacity, the

authority of the agent shall cease, but shall recommence if the principal subsequently loses capacity as determined pursuant to this section.

§ 2984. Provider's obligations. 1. A health care provider who is provided with a health care proxy shall arrange for the proxy or a copy thereof to be inserted in the principal's medical record if the health care proxy has not been included in such record.

2. A health care provider shall comply with health care decisions made by an agent in good faith under a health care proxy to the same extent as if such decisions had been made by the principal, subject to any limitations in the health care proxy and pursuant to the provisions of subdivision five of section two thousand nine hundred eighty-three of this article.

3. Notwithstanding subdivision two of this section, nothing in this article shall be construed to require a private hospital to honor an agent's health care decision that the hospital would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility's operating principles and the hospital would be permitted by law to refuse to honor the decision if made by the principal, provided:

(a) the hospital has informed the patient or the health care agent of such policy prior to or upon admission, if reasonably possible; and

(b) the patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the agent's decision and pending transfer the hospital complies with subdivision five of this section. If the agent is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. If such a transfer is not effected, the hospital shall seek judicial relief in accordance with section twenty-nine hundred ninety-two of this article or honor the agent's decision.

4. Notwithstanding subdivision two of this section, nothing in this

article shall be construed to require an individual as a health care provider to honor an agent's health care decision that the individual would not honor if the decision had been made by the principal because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the health care agent and the hospital of his or her refusal to honor the agent's decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual health care provider willing to honor the agent's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient and comply with subdivision five of this section.

5. Notwithstanding the provisions of this section or subdivision two of section twenty-nine hundred eighty-nine of this article, if an agent directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the patient, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the agent's decision pending either transfer of the patient to a willing hospital or individual health care provider, or judicial review in accordance with section twenty-nine hundred ninety-two of this article.

§ 2985. Revocation. 1. Means of revoking proxy. (a) A competent adult may revoke a health care proxy by notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the proxy.

(b) For the purposes of this section, every adult shall be presumed competent unless determined otherwise pursuant to court order.

(c) A health care proxy shall also be revoked upon execution by the principal of a subsequent health care proxy.

(d) The creation by the principal of written wishes or instructions about health care, or limitations upon the agent's authority, shall not revoke a health care proxy unless such wishes, instructions or limitations expressly provide otherwise. Such wishes, instructions or limitations shall constitute evidence of the principal's wishes for

purposes of subdivision two of section two thousand nine hundred eighty-two of this article.

(e) The appointment of the principal's spouse as health care agent shall be revoked upon the divorce or legal separation of the principal and spouse, unless the principal specifies otherwise.

2. Duty to record revocation. (a) A physician, physician assistant, or nurse practitioner who is informed of or provided with a revocation of a health care proxy shall immediately (i) record the revocation in the principal's medical record and (ii) notify the agent and the medical staff responsible for the principal's care of the revocation.

(b) Any member of the staff of a health care provider informed of or provided with a revocation of a health care proxy pursuant to this section shall immediately notify a physician, physician assistant, or nurse practitioner of such revocation.

§ 2986. Immunity. 1. Provider immunity. No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring in good faith a health care decision by an agent, or for other actions taken in good faith pursuant to this article.

2. Agent immunity. No person acting as agent pursuant to a health care proxy shall be subjected to criminal or civil liability for making a health care decision in good faith pursuant to this article.

§ 2987. Liability for health care costs. Liability for the cost of health care provided pursuant to an agent's decision shall be the same as if the health care were provided pursuant to the principal's decision.

§ 2988. Requiring or prohibiting execution of proxy. No person may require or prohibit the execution of a health care proxy by an individual as a condition for providing health care services or

insurance to such individual.

§ 2989. Effect on other rights. 1. A competent adult's failure to appoint a health care agent or to provide the agent with specific health care instructions pursuant to this article shall create no presumptions regarding the adult's wishes about health care.

2. Nothing in this article creates, expands, diminishes, impairs or supersedes any authority that a principal may have under law to make or express decisions, wishes or instructions regarding health care, including decisions about life sustaining treatment, whether or not expressed in a health care proxy.

3. This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law.

§ 2990. Proxies executed in other states. A health care proxy or similar instrument executed in another state or jurisdiction in compliance with the law of that state or jurisdiction shall be considered validly executed for purposes of this article.

§ 2991. Creation and use of proxies in residential health care and mental hygiene facilities. 1. Residential health care facilities and mental hygiene facilities shall establish procedures:

(a) to provide information to adult residents about their right to create a health care proxy under this article;

(b) to educate adult residents about the authority delegated under a health care proxy, what a proxy may include or omit, and how a proxy is created and revoked;

(c) to help ensure that each resident who creates a proxy while residing at the facility does so voluntarily.

2. Such procedures shall be established in accordance with regulations issued by the commissioners of health, mental health, and the office for people with developmental disabilities for facilities subject to their respective regulatory authorities.

§ 2992. Special proceeding authorized. The health care provider or guardian of the principal under article eighty-one of the mental hygiene law or article seventeen-A of the surrogate's court procedure act, members of the principal's family, a close friend of the principal as defined in subdivision four of section twenty-nine hundred ninety-four-a of this chapter, or the commissioner, the commissioner of mental health, or the commissioner of developmental disabilities may commence a special proceeding pursuant to article four of the civil practice law and rules, in a court of competent jurisdiction, with respect to any dispute arising under this article, including, but not limited to, a proceeding to:

1. determine the validity of the health care proxy;

2. have the agent removed on the ground that the agent (a) is not reasonably available, willing and competent to fulfill his or her obligations under this article; (b) is acting in bad faith; or (c) is the subject of an order of protection protecting the principal or has been arrested or charged for a criminal act that allegedly caused the principal's lack of capacity or substantially injured or impaired the health status of the principal, provided that the application of this provision in a particular case may be waived or modified in the interest of justice; or

3. override the agent's decision about health care treatment on the grounds that: (a) the decision was made in bad faith or (b) the decision is not in accordance with the standards set forth in subdivision one or two of section two thousand nine hundred eighty-two of this article.

§ 2993. Regulations. The commissioner, in consultation with the

commissioners of the office of mental health and the office for people with developmental disabilities, shall establish such regulations as may be necessary for the implementation of this article, subject to the provisions of subdivision two of section twenty-nine hundred ninety-one of this article.

§ 2994. Rights to be publicized. The commissioner of health shall prepare a statement summarizing the rights, duties and requirements of this article and shall require that a copy of such statement:

1. Be furnished to patients or their families at or prior to the time of admission to a hospital, and to each member of the hospital's staff; and

2. Be posted in a public place in each hospital.

The statement of rights required by this section may be included in any other statement of patients' rights required by other provisions of this chapter.

ARTICLE 29-CC

FAMILY HEALTH CARE DECISIONS ACT

Section 2994-a. Definitions.

2994-b. Applicability; priority of certain other surrogate decision-making laws and regulations.

2994-c. Determination of incapacity.

2994-d. Health care decisions for adult patients by surrogates.

2994-e. Decisions about life-sustaining treatment for minor patients.

2994-f. Obligations of attending practitioner.

2994-g. Health care decisions for adult patients without surrogates.

2994-i. Specific policies for orders not to resuscitate.

2994-j. Revocation of consent.

2994-k. Implementation and review of decisions.

2994-l. Interinstitutional transfers.
2994-m. Ethics review committees.
2994-n. Conscience objections.
2994-o. Immunity.
2994-p. Liability for health care costs.
2994-q. Effect on other rights.
2994-r. Special proceeding authorized; court orders; health care guardian for minor patient.
2994-s. Remedy.
2994-t. Regulations.
2994-u. Rights to be publicized.

§ 2994-a. Definitions. The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Adult" means any person who is eighteen years of age or older or has married.

2. "Attending practitioner" means a physician, nurse practitioner or physician assistant, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician, nurse practitioner or physician assistant shares such responsibility, or where a physician, nurse practitioner or physician assistant is acting on the attending practitioner's behalf, any such physician, nurse practitioner or physician assistant may act as an attending practitioner pursuant to this article.

2-a. "Attending nurse practitioner" means a nurse practitioner, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician and/or nurse practitioner shares such responsibility, or where a physician or nurse practitioner is acting on the attending physician's or attending nurse practitioner's behalf, any such physician or nurse practitioner may act as an attending physician

or attending nurse practitioner pursuant to this article.

3. "Cardiopulmonary resuscitation" means measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Cardiopulmonary resuscitation shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

4. "Close friend" means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending practitioner.

5. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.

5-a. "Decisions regarding hospice care" means the decision to enroll or disenroll in hospice, and consent to the hospice plan of care and modifications to that plan.

6. "Developmental disability" means a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law.

7. "Domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

8. "Emancipated minor patient" means a minor patient who is the parent of a child, or who is sixteen years of age or older and living independently from his or her parents or guardian.

9. "Ethics review committee" means the interdisciplinary committee established in accordance with the requirements of section twenty-nine hundred ninety-four-m of this article.

10. "General hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the commissioner of mental health.

11. "Guardian of a minor" or "guardian" means a health care guardian or a legal guardian of the person of a minor.

12. "Health care" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition. Providing nutrition or hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

13. "Health care agent" means a health care agent designated by an adult pursuant to article twenty-nine-C of this chapter.

14. "Health care decision" means any decision to consent or refuse to consent to health care.

15. "Health care guardian" means an individual appointed by a court, pursuant to subdivision four of section twenty-nine hundred ninety-four-r of this article, as the guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article.

16. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

17. "Health or social services practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist, licensed master social worker, or licensed clinical social worker, licensed, certified or authorized under the education law acting within such health or social services practitioner's scope of practice.

17-a. "Hospice" means a hospice as defined in article forty of this chapter, without regard to where the hospice care is provided.

18. "Hospital" means a general hospital, a residential health care facility, or hospice.

19. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short

time, as determined by an attending physician to a reasonable degree of medical certainty. For the purpose of this article, cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

20. "Mental hygiene facility" means a facility operated or licensed by the office of mental health or the office for people with developmental disabilities as defined in subdivision six of section 1.03 of the mental hygiene law.

21. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

22. "Minor" means any person who is not an adult.

22-a. "Nurse practitioner" means a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law who is practicing in accordance with subdivision three of section sixty-nine hundred two of the education law.

23. "Order not to resuscitate" means an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

24. "Parent", for the purpose of a health care decision about a minor patient, means a parent who has custody of, or who has maintained substantial and continuous contact with, the minor patient.

25. "Patient" means a person admitted to a hospital.

26. "Person connected with the case" means the patient, any person on the surrogate list, a parent or guardian of a minor patient, the hospital administrator, an attending practitioner, any other health or social services practitioner who is or has been directly involved in the patient's care, and any duly authorized state agency, including the

facility director or regional director for a patient transferred from a mental hygiene facility and the facility director for a patient transferred from a correctional facility.

27. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital.

28. "Residential health care facility" means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter.

29. "Surrogate" means the person selected to make a health care decision on behalf of a patient pursuant to section twenty-nine hundred ninety-four-d of this article.

30. "Surrogate list" means the list set forth in subdivision one of section twenty-nine hundred ninety-four-d of this article.

§ 2994-b. Applicability; priority of certain other surrogate decision-making laws and regulations. 1. This article shall apply to health care decisions regarding health care provided in a hospital, and to decisions regarding hospice care without regard to where the decision is made or where the care is provided, for a patient who lacks decision-making capacity, except as limited by this section.

1-a. This article shall also apply to decisions regarding orders not to resuscitate for a patient who lacks decision-making capacity in a hospital as defined by section 1.03 of the mental hygiene law.

2. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, the attending practitioner shall make reasonable efforts to determine whether the patient has a health care agent appointed pursuant to article twenty-nine-C of this chapter. If so, health care decisions for the patient shall be governed by such article, and shall have priority over decisions by any other

person except the patient or as otherwise provided in the health care proxy.

3. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, if the attending practitioner has reason to believe that the patient has a history of receiving services for an intellectual or developmental disability; it reasonably appears to the attending practitioner that the patient has an intellectual or developmental disability; or the practitioner in a general hospital has reason to believe that the patient has been temporarily transferred from a mental hygiene facility operated or licensed by the office of mental health or the office for people with developmental disabilities, then such physician, nurse practitioner or physician assistant shall make reasonable efforts to determine whether paragraph (a), (b) or (c) of this subdivision is applicable:

(a) If the patient has a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act, health care decisions for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court procedure act and not by this article.

(b) If a patient does not have a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act but falls within the class of persons described in paragraph (a) of subdivision one of section seventeen hundred fifty-b of such act, decisions to withdraw or withhold life-sustaining treatment for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court procedure act and not by this article.

(c) If a health care decision for a patient cannot be made under paragraphs (a) or (b) of this subdivision, but consent for the decision may be provided pursuant to the mental hygiene law or regulations of the office of mental health or the office for people with developmental disabilities, then the decision shall be governed by such statute or regulations and not by this article.

4. If, after reasonable efforts, it is determined that a health care decision for the patient cannot be made pursuant to subdivision two or three of this section, then the health care decision shall be made pursuant to this article.

§ 2994-c. Determination of incapacity. 1. Presumption of capacity. For purposes of this article, every adult shall be presumed to have decision-making capacity unless determined otherwise pursuant to this section or pursuant to court order, or unless a guardian is authorized to decide about health care for the adult pursuant to article eighty-one of the mental hygiene law.

2. Initial determination by attending practitioner. An attending practitioner shall make an initial determination that an adult patient lacks decision-making capacity to a reasonable degree of medical certainty. Such determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity.

3. Concurring determinations. (a) An initial determination that a patient lacks decision-making capacity shall be subject to a concurring determination, independently made, where required by this subdivision. A concurring determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity, and shall be included in the patient's medical record. Hospitals shall adopt written policies identifying the training and credentials of health or social services practitioners qualified to provide concurring determinations of incapacity.

(b) (i) In a residential health care facility, a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity.

(ii) In a general hospital a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity if the surrogate's decision concerns the withdrawal or withholding of life-sustaining treatment.

(iii) With respect to decisions regarding hospice care for a patient in a general hospital or residential health care facility, the health or

social services practitioner must be employed by or otherwise formally affiliated with the general hospital or residential health care facility.

(c) (i) If the attending practitioner makes an initial determination that a patient lacks decision-making capacity because of mental illness, either such physician must have the following qualifications, or another physician with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician licensed to practice medicine in New York state, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board. A record of such consultation shall be included in the patient's medical record.

(ii) If the attending practitioner makes an initial determination that a patient lacks decision-making capacity because of a developmental disability, either such physician, nurse practitioner or physician assistant must have the following qualifications, or another professional with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician or clinical psychologist who either is employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law, or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office for people with developmental disabilities, or has been approved by the commissioner of developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or clinical psychologist possess specialized training or three years experience in treating developmental disabilities. A record of such consultation shall be included in the patient's medical record.

(d) If an attending practitioner has determined that the patient lacks decision-making capacity and if the health or social services practitioner consulted for a concurring determination disagrees with the attending practitioner's determination, the matter shall be referred to the ethics review committee if it cannot otherwise be resolved.

4. Informing the patient and surrogate. Notice of a determination that

a surrogate will make health care decisions because the adult patient has been determined to lack decision-making capacity shall promptly be given:

(a) to the patient, where there is any indication of the patient's ability to comprehend the information;

(b) to at least one person on the surrogate list highest in order of priority listed when persons in prior classes are not reasonably available pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article;

(c) if the patient is in a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law or was transferred from a mental hygiene facility, to the director of the mental hygiene facility and to the mental hygiene legal service under article forty-seven of the mental hygiene law.

5. Limited purpose of determination. A determination made pursuant to this section that an adult patient lacks decision-making capacity shall not be construed as a finding that the patient lacks capacity for any other purpose.

6. Priority of patient's decision. Notwithstanding a determination pursuant to this section that an adult patient lacks decision-making capacity, if the patient objects to the determination of incapacity, or to the choice of a surrogate or to a health care decision made by a surrogate or made pursuant to section twenty-nine hundred ninety-four-g of this article, the patient's objection or decision shall prevail unless: (a) a court of competent jurisdiction has determined that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes and, in the case of a patient's objection to treatment, makes any other finding required by law to authorize the treatment, or (b) another legal basis exists for overriding the patient's decision.

7. Confirmation of continued lack of decision-making capacity. An attending practitioner shall confirm the adult patient's continued lack of decision-making capacity before complying with health care decisions made pursuant to this article, other than those decisions made at or

about the time of the initial determination. A concurring determination of the patient's continued lack of decision-making capacity shall be required if the subsequent health care decision concerns the withholding or withdrawal of life-sustaining treatment. Health care providers shall not be required to inform the patient or surrogate of the confirmation.

§ 2994-d. Health care decisions for adult patients by surrogates. 1.

Identifying the surrogate. One person from the following list from the class highest in priority when persons in prior classes are not reasonably available, willing, and competent to act, shall be the surrogate for an adult patient who lacks decision-making capacity. However, such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects:

(a) A guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law;

(b) The spouse, if not legally separated from the patient, or the domestic partner;

(c) A son or daughter eighteen years of age or older;

(d) A parent;

(e) A brother or sister eighteen years of age or older;

(f) A close friend.

2. Restrictions on who may be a surrogate. An operator, administrator, or employee of a hospital or a mental hygiene facility from which the patient was transferred, or a physician, nurse practitioner or physician assistant who has privileges at the hospital or a health care provider under contract with the hospital may not serve as the surrogate for any adult who is a patient of such hospital, unless such individual is related to the patient by blood, marriage, domestic partnership, or adoption, or is a close friend of the patient whose friendship with the patient preceded the patient's admission to the facility. If a physician, nurse practitioner or physician assistant serves as surrogate, the physician, nurse practitioner or physician assistant shall not act as the patient's attending practitioner after his or her authority as surrogate begins.

3. Authority and duties of surrogate. (a) Scope of surrogate's authority.

(i) Subject to the standards and limitations of this article, the surrogate shall have the authority to make any and all health care decisions on the adult patient's behalf that the patient could make.

(ii) Nothing in this article shall obligate health care providers to seek the consent of a surrogate if an adult patient has already made a decision about the proposed health care, expressed orally or in writing or, with respect to a decision to withdraw or withhold life-sustaining treatment expressed either orally during hospitalization in the presence of two witnesses eighteen years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital, or in writing. If an attending practitioner relies on the patient's prior decision, the physician, nurse practitioner or physician assistant shall record the prior decision in the patient's medical record. If a surrogate has already been designated for the patient, the attending practitioner shall make reasonable efforts to notify the surrogate prior to implementing the decision; provided that in the case of a decision to withdraw or withhold life-sustaining treatment, the attending practitioner shall make diligent efforts to notify the surrogate and, if unable to notify the surrogate, shall document the efforts that were made to do so.

(b) Commencement of surrogate's authority. The surrogate's authority shall commence upon a determination, made pursuant to section twenty-nine hundred ninety-four-c of this article, that the adult patient lacks decision-making capacity and upon identification of a surrogate pursuant to subdivision one of this section. In the event an attending practitioner determines that the patient has regained decision-making capacity, the authority of the surrogate shall cease.

(c) Right and duty to be informed. Notwithstanding any law to the contrary, the surrogate shall have the right to receive medical information and medical records necessary to make informed decisions about the patient's health care. Health care providers shall provide and the surrogate shall seek information necessary to make an informed decision, including information about the patient's diagnosis, prognosis, the nature and consequences of proposed health care, and the

benefits and risks of and alternatives to proposed health care.

4. Decision-making standards. (a) The surrogate shall make health care decisions:

(i) in accordance with the patient's wishes, including the patient's religious and moral beliefs; or

(ii) if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. An assessment of the patient's best interests shall include: consideration of the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

(b) In all cases, the surrogate's assessment of the patient's wishes and best interests shall be patient-centered; health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

5. Decisions to withhold or withdraw life-sustaining treatment. In addition to the standards set forth in subdivision four of this section, decisions by surrogates to withhold or withdraw life-sustaining treatment (including decisions to accept a hospice plan of care that provides for the withdrawal or withholding of life-sustaining treatment) shall be authorized only if the following conditions are satisfied, as applicable:

(a)(i) Treatment would be an extraordinary burden to the patient and an attending practitioner determines, with the independent concurrence of another physician, nurse practitioner or physician assistant, that, to a reasonable degree of medical certainty and in accord with accepted medical standards, (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or (B) the patient is permanently unconscious; or

(ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or

extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition, as determined by an attending practitioner with the independent concurrence of another physician, nurse practitioner or physician assistant to a reasonable degree of medical certainty and in accord with accepted medical standards.

(b) In a residential health care facility, a surrogate shall have the authority to refuse life-sustaining treatment under subparagraph (ii) of paragraph (a) of this subdivision only if the ethics review committee, including at least one physician, nurse practitioner or physician assistant who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this article. This requirement shall not apply to a decision to withhold cardiopulmonary resuscitation.

(c) In a general hospital, if the attending practitioner objects to a surrogate's decision, under subparagraph (ii) of paragraph (a) of this subdivision, to withdraw or withhold nutrition and hydration provided by means of medical treatment, the decision shall not be implemented until the ethics review committee, including at least one physician, nurse practitioner or physician assistant who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this subdivision and subdivision four of this section.

(d) Providing nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

(e) Expression of decisions. The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either orally to an attending practitioner or in writing.

§ 2994-e. Decisions about life-sustaining treatment for minor patients. 1. Authority of parent or guardian. The parent or guardian of a minor patient shall have the authority to make decisions about life-sustaining treatment, including decisions to withhold or withdraw such treatment, subject to the provisions of this section and subdivision five of section twenty-nine hundred ninety-four-d of this article.

2. Decision-making standards and procedures for minor patient. (a) The parent or guardian of a minor patient shall make decisions in accordance with the minor's best interests, consistent with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article, taking into account the minor's wishes as appropriate under the circumstances.

(b) An attending practitioner, in consultation with a minor's parent or guardian, shall determine whether a minor patient has decision-making capacity for a decision to withhold or withdraw life-sustaining treatment. If the minor has such capacity, a parent's or guardian's decision to withhold or withdraw life-sustaining treatment for the minor may not be implemented without the minor's consent.

(c) Where a parent or guardian of a minor patient has made a decision to withhold or withdraw life-sustaining treatment and an attending practitioner has reason to believe that the minor patient has a parent or guardian who has not been informed of the decision, including a non-custodial parent or guardian, an attending practitioner or someone acting on his or her behalf, shall make reasonable efforts to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the minor and, if so, shall make diligent efforts to notify that parent or guardian prior to implementing the decision.

3. Decision-making standards and procedures for emancipated minor patient. (a) If an attending practitioner determines that a patient is an emancipated minor patient with decision-making capacity and documents the basis for that determination in the patient's medical record, the patient shall have the authority to decide about life-sustaining treatment. That authority shall include a decision to withhold or withdraw life-sustaining treatment if an attending practitioner and the ethics review committee determine that the decision accords with the standards for surrogate decisions for adults, and the ethics review committee approves the decision.

(b) If the hospital can with reasonable efforts ascertain the identity of the parents or guardian of an emancipated minor patient and obtain such parents' or guardian's contact information, the hospital shall

notify such persons, and document such notification in the patient's medical record, prior to withholding or withdrawing life-sustaining treatment pursuant to this subdivision.

§ 2994-f. Obligations of attending practitioner. 1. An attending practitioner informed of a decision to withdraw or withhold life-sustaining treatment made pursuant to the standards of this article shall record the decision in the patient's medical record, review the medical basis for the decision, and shall either: (a) implement the decision, or (b) promptly make his or her objection to the decision and the reasons for the objection known to the decision-maker, and either make all reasonable efforts to arrange for the transfer of the patient to another physician, nurse practitioner or physician assistant, if necessary, or promptly refer the matter to the ethics review committee.

2. If an attending practitioner has actual notice of the following objections or disagreements, he or she shall promptly refer the matter to the ethics review committee if the objection or disagreement cannot otherwise be resolved:

(a) A health or social services practitioner consulted for a concurring determination that an adult patient lacks decision-making capacity disagrees with the attending practitioner's determination; or

(b) Any person on the surrogate list objects to the designation of the surrogate pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article; or

(c) Any person on the surrogate list objects to a surrogate's decision; or

(d) A parent or guardian of a minor patient objects to the decision by another parent or guardian of the minor; or

(e) A minor patient refuses life-sustaining treatment, and the minor's parent or guardian wishes the treatment to be provided, or the minor patient objects to an attending practitioner's determination about decision-making capacity or recommendation about life-sustaining treatment.

3. Notwithstanding the provisions of this section or subdivision one

of section twenty-nine hundred ninety-four-q of this article, if a surrogate directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the patient, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the surrogate's decision pending either transfer of the patient to a willing hospital or individual health care provider, or judicial review in accordance with section twenty-nine hundred ninety-four-r of this article.

§ 2994-g. Health care decisions for adult patients without surrogates.

1. Identifying adult patients without surrogates. Within a reasonable time after admission as an inpatient to the hospital of each adult patient, the hospital shall make reasonable efforts to determine if the patient has appointed a health care agent or has a guardian, or if at least one individual is available to serve as the patient's surrogate in the event the patient lacks or loses decision-making capacity. With respect to a patient who lacks capacity, if no such health care agent, guardian or potential surrogate is identified, the hospital shall identify, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending health care decisions, and shall record its findings in the patient's medical record.

2. Decision-making standards and procedures. (a) The procedures specified in this and the following subdivisions of this section apply to health care decisions for adult patients who would qualify for surrogate decision-making under this article but for whom no surrogate is reasonably available, willing or competent to act.

(b) Any health care decision made pursuant to this section shall be made in accordance with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article and shall not be based on the financial interests of the hospital or any other health care provider. The specific procedures to be followed depend on whether the decision involves routine medical treatment, major medical treatment, or the withholding or withdrawal of life-sustaining

treatment, and the location where the treatment is provided.

3. Routine medical treatment. (a) For purposes of this subdivision, "routine medical treatment" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition, such as the administration of medication, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic, for which health care providers ordinarily do not seek specific consent from the patient or authorized representative. It shall not include the long-term provision of treatment such as ventilator support or a nasogastric tube but shall include such treatment when provided as part of post-operative care or in response to an acute illness and recovery is reasonably expected within one month or less.

(b) An attending practitioner shall be authorized to decide about routine medical treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article. Nothing in this subdivision shall require health care providers to obtain specific consent for treatment where specific consent is not otherwise required by law.

4. Major medical treatment. (a) For purposes of this subdivision, "major medical treatment" means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition: (i) where general anesthetic is used; or (ii) which involves any significant risk; or (iii) which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or (iv) which involves the use of physical restraints, as specified in regulations promulgated by the commissioner, except in an emergency; or (v) which involves the use of psychoactive medications, except when provided as part of post-operative care or in response to an acute illness and treatment is reasonably expected to be administered over a period of forty-eight hours or less, or when provided in an emergency.

(b) A decision to provide major medical treatment, made in accordance with the following requirements, shall be authorized for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article.

(i) An attending practitioner shall make a recommendation in consultation with hospital staff directly responsible for the patient's care.

(ii) In a general hospital, at least one other physician, nurse practitioner or physician assistant designated by the hospital must independently determine that he or she concurs that the recommendation is appropriate.

(iii) In a residential health care facility, and for a hospice patient not in a general hospital, the medical director of the facility or hospice, or a physician, nurse practitioner or physician assistant designated by the medical director, must independently determine that he or she concurs that the recommendation is appropriate; provided that if the medical director is the patient's attending practitioner, a different physician, nurse practitioner or physician assistant designated by the residential health care facility or hospice must make this independent determination. Any health or social services practitioner employed by or otherwise formally affiliated with the facility or hospice may provide a second opinion for decisions about physical restraints made pursuant to this subdivision.

5. Decisions to withhold or withdraw life-sustaining treatment. (a) A court of competent jurisdiction may make a decision to withhold or withdraw life-sustaining treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article if the court finds that the decision accords with standards for decisions for adults set forth in subdivisions four and five of section twenty-nine hundred ninety-four-d of this article.

(b) If the attending practitioner, with independent concurrence of a second physician, nurse practitioner or physician assistant designated by the hospital, determines to a reasonable degree of medical certainty that:

(i) life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and

(ii) the provision of life-sustaining treatment would violate accepted medical standards, then such treatment may be withdrawn or withheld from

an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article, without judicial approval. This paragraph shall not apply to any treatment necessary to alleviate pain or discomfort.

5-a. Decisions regarding hospice care. An attending practitioner shall be authorized to make decisions regarding hospice care and execute appropriate documents for such decisions (including a hospice election form) for an adult patient under this section who is hospice eligible in accordance with the following requirements.

(a) The attending practitioner shall make decisions under this section in consultation with staff directly responsible for the patient's care, and shall base his or her decisions on the standards for surrogate decisions set forth in subdivisions four and five of section twenty-nine hundred ninety-four-d of this article;

(b) There is a concurring opinion as follows:

(i) in a general hospital, at least one other physician, nurse practitioner or physician assistant designated by the hospital must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions;

(ii) in a residential health care facility, the medical director of the facility, or a physician, nurse practitioner or physician assistant designated by the medical director, must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending practitioner, a different physician, nurse practitioner or physician assistant designated by the residential health care facility must make this independent determination; or

(iii) in settings other than a general hospital or residential health care facility, the medical director of the hospice, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is medically appropriate and consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending physician, a different physician designated by the hospice must make this independent determination; and

(c) The ethics review committee of the general hospital, residential

health care facility or hospice, as applicable, including at least one physician, nurse practitioner or physician assistant who is not the patient's attending practitioner, or a court of competent jurisdiction, must review the decision and determine that it is consistent with such standards for surrogate decisions. This requirement shall not apply to decisions about routine medical treatment. Such decisions shall be governed by subdivision three of this section.

6. Physician, nurse practitioner or physician assistant objection. If a physician, nurse practitioner or physician assistant consulted for a concurring opinion objects to an attending practitioner's recommendation or determination made pursuant to this section, or a member of the hospital staff directly responsible for the patient's care objects to an attending practitioner's recommendation about major medical treatment or treatment without medical benefit, the matter shall be referred to the ethics review committee if it cannot be otherwise resolved.

§ 2994-i. Specific policies for orders not to resuscitate. An order not to resuscitate shall be written in the patient's medical record. Consent to an order not to resuscitate shall not constitute consent to withhold or withdraw treatment other than cardiopulmonary resuscitation.

§ 2994-j. Revocation of consent. 1. A patient, surrogate, or parent or guardian of a minor patient may at any time revoke his or her consent to withhold or withdraw life-sustaining treatment by informing an attending practitioner or a member of the medical or nursing staff of the revocation.

2. An attending practitioner informed of a revocation of consent made pursuant to this section shall immediately:

- (a) record the revocation in the patient's medical record;
- (b) cancel any orders implementing the decision to withhold or withdraw treatment; and
- (c) notify the hospital staff directly responsible for the patient's care of the revocation and any cancellations.

3. Any member of the medical or nursing staff, other than a nurse practitioner or physician assistant, informed of a revocation made pursuant to this section shall immediately notify an attending practitioner of the revocation.

§ 2994-k. Implementation and review of decisions. 1. Hospitals shall adopt written policies requiring implementation and regular review of decisions to withhold or withdraw life-sustaining treatment in accordance with accepted medical standards. Hospitals shall also develop policies in accord with accepted medical standards regarding documentation of clinical determinations and decisions by surrogates and health care providers pursuant to this article.

2. If a decision to withhold or withdraw life-sustaining treatment has been made pursuant to this article, and an attending practitioner determines at any time that the decision is no longer appropriate or authorized because the patient has regained decision-making capacity or because the patient's condition has otherwise improved, the physician, nurse practitioner or physician assistant shall immediately:

(a) include such determination in the patient's medical record;

(b) cancel any orders or plans of care implementing the decision to withhold or withdraw life-sustaining treatment;

(c) notify the person who made the decision to withhold or withdraw treatment, or, if that person is not reasonably available, to at least one person on the surrogate list highest in order of priority listed when persons in prior classes are not reasonably available pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article; and

(d) notify the hospital staff directly responsible for the patient's care of any cancelled orders or plans of care.

§ 2994-l. Interinstitutional transfers. 1. If a patient with an order to withhold or withdraw life-sustaining treatment is transferred from a mental hygiene facility to a hospital or from a hospital to a different

hospital, any such order or plan shall remain effective until an attending practitioner first examines the transferred patient, whereupon an attending practitioner must either:

(a) Issue appropriate orders to continue the prior order or plan. Such orders may be issued without obtaining another consent to withhold or withdraw life-sustaining treatment pursuant to this article; or

(b) Cancel such order, if the attending practitioner determines that the order is no longer appropriate or authorized. Before canceling the order the attending practitioner shall make reasonable efforts to notify the person who made the decision to withhold or withdraw treatment and the hospital staff directly responsible for the patient's care of any such cancellation. If such notice cannot reasonably be made prior to canceling the order or plan, the attending practitioner shall make such notice as soon as reasonably practicable after cancellation.

2. Orders to withhold or withdraw life-sustaining treatment shall remain effective and no affirmative action by a general hospital shall be required pursuant to this section where a patient is transferred within a general hospital between a medical unit and a ward, wing, unit, or other part of the general hospital which is operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the commissioner of mental health.

§ 2994-m. Ethics review committees. 1. Establishment of an ethics review committee, written policy. Each hospital shall establish at least one ethics review committee or participate in an ethics review committee that serves more than one hospital, and shall adopt a written policy governing committee functions, composition, and procedure, in accordance with the requirements of this article. A hospital may designate an existing committee, or subcommittee thereof, to carry out the functions of the ethics review committee provided the requirements of this section are satisfied.

2. Functions of the ethics review committee. (a) The ethics review committee shall consider and respond to any health care matter presented to it by a person connected with the case.

(b) The ethics review committee response to a health care matter may include:

- (i) providing advice on the ethical aspects of proposed health care;
- (ii) making a recommendation about proposed health care; or
- (iii) providing assistance in resolving disputes about proposed health care.

(c) Recommendations and advice by the ethics review committee shall be advisory and nonbinding, except as specified in subdivision five of section twenty-nine hundred ninety-four-d of this article and subdivision three of section twenty-nine hundred ninety-four-e of this article.

3. Committee membership. The membership of ethics review committees must be interdisciplinary and must include at least five members who have demonstrated an interest in or commitment to patient's rights or to the medical, public health, or social needs of those who are ill. At least three ethics review committee members must be health or social services practitioners, at least one of whom must be a registered nurse and one of whom must be a physician, nurse practitioner or physician assistant. At least one member must be a person without any governance, employment or contractual relationship with the hospital. In a residential health care facility the facility must offer the residents' council of the facility (or of another facility that participates in the committee) the opportunity to appoint up to two persons to the ethics review committee, none of whom may be a resident of or a family member of a resident of such facility, and both of whom shall be persons who have expertise in or a demonstrated commitment to patient rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a health care provider.

4. Procedures for ethics review committee. (a) These procedures are required only when: (i) the ethics review committee is convened to review a decision by a surrogate to withhold or withdraw life-sustaining treatment for: (A) a patient in a residential health care facility pursuant to paragraph (b) of subdivision five of section twenty-nine hundred ninety-four-d of this article; (B) a patient in a general

hospital pursuant to paragraph (c) of subdivision five of section twenty-nine hundred ninety-four-d of this article; or (C) an emancipated minor patient pursuant to subdivision three of section twenty-nine hundred ninety-four-e of this article; or (ii) when a person connected with the case requests the ethics review committee to provide assistance in resolving a dispute about proposed care. Nothing in this section shall bar health care providers from first striving to resolve disputes through less formal means, including the informal solicitation of ethical advice from any source.

(b)(i) A person connected with the case may not participate as an ethics review committee member in the consideration of that case.

(ii) The ethics review committee shall respond promptly, as required by the circumstances, to any request for assistance in resolving a dispute or consideration of a decision to withhold or withdraw life-sustaining treatment pursuant to paragraphs (b) and (c) of subdivision five of section twenty-nine hundred ninety-four-d of this article made by a person connected with the case. The committee shall permit persons connected with the case to present their views to the committee, and to have the option of being accompanied by an advisor when participating in a committee meeting.

(iii) The ethics review committee shall promptly provide the patient, where there is any indication of the patient's ability to comprehend the information, the surrogate, other persons on the surrogate list directly involved in the decision or dispute regarding the patient's care, any parent or guardian of a minor patient directly involved in the decision or dispute regarding the minor patient's care, an attending practitioner, the hospital, and other persons the committee deems appropriate, with the following:

(A) notice of any pending case consideration concerning the patient, including, for patients, persons on the surrogate list, parents and guardians, information about the ethics review committee's procedures, composition and function; and

(B) the committee's response to the case, including a written statement of the reasons for approving or disapproving the withholding or withdrawal of life-sustaining treatment for decisions considered pursuant to subparagraph (ii) of paragraph (a) of subdivision five of section twenty-nine hundred ninety-four-d of this article. The

committee's response to the case shall be included in the patient's medical record.

(iv) Following ethics review committee consideration of a case concerning the withdrawal or withholding of life-sustaining treatment, treatment shall not be withdrawn or withheld until the hospital makes diligent efforts to inform the persons identified in subparagraph (iii) of this paragraph have been informed of the committee's response to the case and documents the diligent efforts in the patient's medical record.

(c) When an ethics review committee is convened to review decisions regarding hospice care for a patient in a general hospital or residential health care facility, the responsibilities of this section shall be carried out by the ethics review committee of the general hospital or residential health care facility, provided that such committee shall invite a representative from hospice to participate.

5. Access to medical records and information; patient confidentiality. Ethics review committee members and consultants shall have access to medical information and medical records necessary to perform their function under this article. Any such information or records disclosed to committee members, consultants, or others shall be kept confidential except to the extent necessary to accomplish the purposes of this article or as otherwise provided by law.

6. Ethics review committee confidentiality. Notwithstanding any other provisions of law, the proceedings and records of an ethics review committee shall be kept confidential and shall not be released by committee members, committee consultants, or other persons privy to such proceedings and records; the proceedings and records of an ethics review committee shall not be subject to disclosure or inspection in any manner, including under article six of the public officers law or article thirty-one of the civil practice law and rules; and, no person shall testify as to the proceedings or records of an ethics review committee, nor shall such proceedings and records otherwise be admissible as evidence in any action or proceeding of any kind in any court or before any other tribunal, board, agency or person, except that:

(a) Ethics review committee proceedings and records, in cases where a

committee approves or disapproves of the withholding or withdrawal of life-sustaining treatment pursuant to subdivision five of section twenty-nine hundred ninety-four-d of this article, or subdivision three of section twenty-nine hundred ninety-four-e of this article, may be obtained by or released to the department;

(b) Nothing in this subdivision shall prohibit the patient, the surrogate, other persons on the surrogate list, or a parent or guardian of a minor patient from voluntarily disclosing, releasing or testifying about committee proceedings or records; and

(c) Nothing in this subdivision shall prohibit the justice center for the protection of people with special needs or any agency or person within or under contract with the justice center which provides protection and advocacy services from requiring any information, report or record from a hospital in accordance with the provisions of section five hundred fifty-eight of the executive law.

§ 2994-n. Conscience objections. 1. Private hospitals. Nothing in this article shall be construed to require a private hospital to honor a health care decision made pursuant to this article if:

(a) The decision is contrary to a formally adopted policy of the hospital that is expressly based on sincerely held religious beliefs or sincerely held moral convictions central to the facility's operating principles;

(b) The hospital has informed the patient, family, or surrogate of such policy prior to or upon admission, if reasonably possible; and

(c) The patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and willing to honor the decision and pending transfer the hospital complies with subdivision three of section twenty-nine hundred ninety-four-f of this article. If the patient's family or surrogate is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. If such a transfer is not effected, the hospital shall seek judicial relief in accordance with section twenty-nine hundred ninety-four-r of this article or honor the decision.

2. Individual health care providers. Nothing in this article shall be

construed to require an individual as a health care provider to honor a health care decision made pursuant to this article if:

(a) the decision is contrary to the individual's sincerely held religious beliefs or sincerely held moral conviction; and

(b) the individual health care provider promptly informs the person who made the decision and the hospital of his or her refusal to honor the decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual health care provider willing to honor the decision. The individual health care provider shall cooperate in facilitating such transfer and comply with subdivision three of section twenty-nine hundred ninety-four-f of this article.

§ 2994-o. Immunity. 1. Ethics review committee. No person shall be subject to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for acts performed reasonably and in good faith pursuant to this article as a member of or as a consultant to an ethics review committee or as a participant in an ethics review committee meeting.

2. Providers. No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith a health care decision made pursuant to this article or for other actions taken reasonably and in good faith pursuant to this article.

3. Surrogates and guardians. No person shall be subjected to criminal or civil liability for making a health care decision reasonably and in good faith pursuant to this article or for other actions taken reasonably and in good faith pursuant to this article.

§ 2994-p. Liability for health care costs. Liability for the cost of health care provided to an adult patient pursuant to this article shall be the same as if the health care were provided pursuant to the patient's decision. No person shall become liable for the cost of health

care for a minor solely by virtue of making a decision as a guardian of a minor pursuant to this article.

§ 2994-q. Effect on other rights. 1. Nothing in this article creates, expands, diminishes, impairs, or supersedes any authority that an individual may have under law to make or express decisions, wishes, or instructions regarding health care on his or her own behalf, including decisions about life-sustaining treatment.

2. Nothing in this article shall affect existing law concerning implied consent to health care in an emergency.

3. Nothing in this article is intended to permit or promote suicide, assisted suicide, or euthanasia.

4. This article shall not affect existing law with respect to sterilization.

5. Nothing in this article diminishes the duty of parents and legal guardians under existing law to consent to treatment for minors.

§ 2994-r. Special proceeding authorized; court orders; health care guardian for minor patient. 1. Special proceeding. Any person connected with the case and any member of the hospital ethics review committee may commence a special proceeding pursuant to article four of the civil practice law and rules in a court of competent jurisdiction with respect to any matter arising under this article.

2. Court orders designating surrogate. A court of competent jurisdiction may designate any individual from the surrogate list to act as surrogate, regardless of that individual's priority on the list, if the court determines that such appointment would best accord with the patient's wishes or, if the patient's wishes are not reasonably known, with the patient's best interests. The court may remove a surrogate on the ground that the surrogate: (a) is not reasonably available, willing

and competent to fulfill his or her obligations under this article; (b) is acting in bad faith; or (c) is the subject of an order of protection protecting the patient or has been arrested or charged for a criminal act that allegedly caused the patient's lack of capacity or substantially injured or impaired the health status of the patient, provided that the application of this provision in a particular case may be waived or modified in the interest of justice. Unless otherwise determined by a court, no surrogate decision made prior to an order designating a surrogate shall be deemed to have been invalid because of the issuance of a designating order.

3. Court orders to withhold or withdraw life-sustaining treatment. A court of competent jurisdiction may authorize the withholding or withdrawal of life-sustaining treatment from a person if the court determines that the person lacks decision-making capacity, and withdrawing or withholding the treatment would accord with the standards set forth in subdivision five of section twenty-nine hundred ninety-four-d of this article.

4. Health care guardian for a minor patient. (a) No appointment shall be made pursuant to this subdivision if a parent or legal guardian of the person is available, willing, and competent to decide about treatment for the minor.

(b) The following persons may commence a special proceeding in a court of competent jurisdiction to seek appointment as the health care guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article:

(i) the hospital administrator;

(ii) an attending practitioner;

(iii) the local commissioner of social services or the local commissioner of health, authorized to make medical treatment decisions for the minor pursuant to section three hundred eighty-three-b of the social services law; or

(iv) an individual, eighteen years of age or older, who has assumed care of the minor for a substantial and continuous period of time.

(c) Notice of the proceeding shall be given to the persons identified in section seventeen hundred five of the surrogate's court procedure

act.

(d) Notwithstanding any other provision of law, seeking appointment or being appointed as a health care guardian shall not otherwise affect the legal status or rights of the individual seeking or obtaining such appointment.

§ 2994-s. Remedy. 1. Any hospital, attending practitioner that refuses to honor a health care decision by a surrogate made pursuant to this article and in accord with the standards set forth in this article shall not be entitled to compensation for treatment, services, or procedures refused by the surrogate, except that this subdivision shall not apply:

(a) when a hospital, physician, nurse practitioner or physician assistant exercises the rights granted by section twenty-nine hundred ninety-four-n of this article, provided that the physician, nurse practitioner, physician assistant or hospital promptly fulfills the obligations set forth in section twenty-nine hundred ninety-four-n of this article;

(b) while a matter is under consideration by the ethics review committee, provided that the matter is promptly referred to and considered by the committee;

(c) in the event of a dispute between individuals on the surrogate list; or

(d) if the physician, nurse practitioner, physician assistant or hospital prevails in any litigation concerning the surrogate's decision to refuse the treatment, services or procedure. Nothing in this section shall determine or affect how disputes among individuals on the surrogate list are resolved.

2. The remedy provided in this section is in addition to and cumulative with any other remedies available at law or in equity or by administrative proceedings to a patient, a health care agent appointed pursuant to article twenty-nine-C of this chapter, or a person authorized to make health care decisions pursuant to this article, including injunctive and declaratory relief, and any other provisions of this chapter governing fines, penalties, or forfeitures.

§ 2994-t. Regulations. 1. The commissioner shall establish such regulations as may be necessary to implement this article.

2. The commissioner, in consultation with the commissioners of the office of mental health and the office for people with developmental disabilities, shall promulgate regulations identifying the credentials of health care professionals qualified to provide an independent determination, pursuant to subdivision three of section twenty-nine hundred ninety-four-c of this article, that a patient lacks decision-making capacity because of mental illness or developmental disability.

§ 2994-u. Rights to be publicized. The commissioner shall prepare a statement summarizing the rights, duties, and requirements of this article and shall require that a copy of such statement be furnished to a patient or to the patient's surrogate, or to the parent or guardian of a minor patient, at or prior to admission to the hospital, or within a reasonable time thereafter, and to any person on the surrogate list who requests a copy of the statement from the hospital. The statement shall also be made available to the hospital clinical staff.

ARTICLE 29-CCC

NONHOSPITAL ORDERS NOT TO RESUSCITATE

Section 2994-aa. Definitions.

2994-bb. General provisions.

2994-cc. Consent to a nonhospital order not to resuscitate.

2994-dd. Managing a nonhospital order not to resuscitate.

2994-ee. Obligation to honor a nonhospital order not to resuscitate.

2994-ff. Interinstitutional transfer.

2994-gg. Immunity.

§ 2994-aa. Definitions. 1. "Adult" means any person who is eighteen

years of age or older, or is the parent of a child or has married.

2. "Attending practitioner" means the physician, nurse practitioner or physician assistant who has primary responsibility for the treatment and care of the patient. Where more than one physician, nurse practitioner or physician assistant shares such responsibility, any such physician, nurse practitioner or physician assistant may act as the attending practitioner pursuant to this article.

2-a. "Attending nurse practitioner" means the nurse practitioner who has primary responsibility for the treatment and care of the patient. Where more than one physician and/or nurse practitioner shares such responsibility, any such physician or nurse practitioner may act as the attending physician or attending nurse practitioner pursuant to this article.

3. "Capacity" means the ability to understand and appreciate the nature and consequences of a nonhospital order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order.

4. "Cardiopulmonary resuscitation" means measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Such term shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

5. "Emergency medical services personnel" means the personnel of a service or agency engaged in providing initial emergency medical assistance, including but not limited to first responders, emergency medical technicians, advanced emergency medical technicians and personnel engaged in providing health care at correctional facilities, as that term is defined in subdivision four of section two of the correction law.

6. "Health care agent" means a health care agent of the patient designated pursuant to article twenty-nine-C of this chapter.

7. "Health or social services practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or certified, licensed master social worker or licensed clinical social worker, licensed or certified pursuant to the education law, acting within his or her scope of practice.

8. "Home care services agency" means an entity certified, licensed or exempt under article thirty-six of this chapter.

9. "Hospice" means a hospice as defined in article forty of this chapter.

10. "Hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter and a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law or a developmental disabilities services office named in section 13.17 of the mental hygiene law.

11. "Hospital emergency services personnel" means the personnel of the emergency service of a general hospital, as defined in subdivision ten of section twenty-eight hundred one of this chapter, including but not limited to emergency services attending physicians, emergency services registered professional nurses, and registered professional nurses, nursing staff and registered physician assistants assigned to the general hospital's emergency service.

13. "Nonhospital order not to resuscitate" means an order that directs emergency medical services personnel, hospice personnel, home care services agency personnel and hospital emergency services personnel not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

13-a. "Nurse practitioner" means a nurse practitioner certified pursuant to section sixty-nine hundred ten of the education law who is

practicing in accordance with subdivision three of section sixty-nine hundred two of the education law.

14. "Patient" means a person who has been or who may be issued a nonhospital order not to resuscitate.

15. "Surrogate" means a person authorized to make a health care decision on behalf of a patient pursuant to article twenty-nine-CC of this chapter.

§ 2994-bb. General provisions. 1. (a) Emergency medical services personnel, home care services agency personnel, hospice personnel, and hospital emergency services personnel shall honor nonhospital orders not to resuscitate, except as provided in section twenty-nine hundred ninety-four-ee of this article.

(b) A nonhospital order not to resuscitate shall not constitute an order to withhold or withdraw treatment other than cardiopulmonary resuscitation.

2. A nonhospital order not to resuscitate may be issued during hospitalization to take effect after hospitalization, or may be issued for a person who is not a patient in, or a resident of, a hospital.

§ 2994-cc. Consent to a nonhospital order not to resuscitate. 1. An adult with decision-making capacity, a health care agent, or a surrogate may consent to a nonhospital order not to resuscitate orally to the attending practitioner or in writing. If a patient consents to a nonhospital order not to resuscitate while in a correctional facility, notice of the patient's consent shall be given to the facility director and reasonable efforts shall be made to notify an individual designated by the patient to receive such notice prior to the issuance of the nonhospital order not to resuscitate. Notification to the facility director or the individual designated by the patient shall not delay issuance of a nonhospital order not to resuscitate.

2. Consent by a health care agent shall be governed by article twenty-nine-C of this chapter.

3. Consent by a surrogate shall be governed by article twenty-nine-CC of this chapter, except that: (a) a second determination of capacity shall be made by a health or social services practitioner; and (b) the authority of the ethics review committee set forth in article twenty-nine-CC of this chapter shall apply only to nonhospital orders issued in a hospital.

4. (a) When the concurrence of a second physician, nurse practitioner or physician assistant is sought to fulfill the requirements for the issuance of a nonhospital order not to resuscitate for patients in a correctional facility, such second physician, nurse practitioner or physician assistant shall be selected by the chief medical officer of the department of corrections and community supervision or his or her designee.

(b) When the concurrence of a second physician, nurse practitioner or physician assistant is sought to fulfill the requirements for the issuance of a nonhospital order not to resuscitate for hospice and home care patients, such second physician, nurse practitioner or physician assistant shall be selected by the hospice medical director or hospice nurse coordinator designated by the medical director or by the home care services agency director of patient care services, as appropriate to the patient.

5. Consent by a patient or a surrogate for a patient in a residential facility operated or licensed by the office of mental health, other than a hospital as defined in section 1.03 of the mental hygiene law, shall be governed by this article. Consent by a patient who is intellectually or otherwise developmentally disabled and is eligible for life-sustaining treatment decision pursuant to section seventeen hundred fifty-b of the surrogate's court procedure act shall be governed by that section.

§ 2994-dd. Managing a nonhospital order not to resuscitate. 1. The

attending practitioner shall record the issuance of a nonhospital order not to resuscitate in the patient's medical record.

2. A nonhospital order not to resuscitate shall be issued upon a standard form prescribed by the commissioner. A standard bracelet or other article may be worn by a patient with a nonhospital order not to resuscitate to identify that status; provided, however, that no person may require a patient to wear such an article and that no person may require a patient to wear such an article as a condition for honoring a nonhospital order not to resuscitate or for providing health care services.

3. An attending practitioner who has issued a nonhospital order not to resuscitate, and who transfers care of the patient to another physician, nurse practitioner or physician assistant, shall inform the physician, nurse practitioner or physician assistant of the order.

4. For each patient for whom a nonhospital order not to resuscitate has been issued, the attending practitioner shall review whether the order is still appropriate in light of the patient's condition each time he or she examines the patient, whether in the hospital or elsewhere, but at least every ninety days, provided that the review need not occur more than once every seven days. The attending practitioner shall record the review in the patient's medical record provided, however, that a physician assistant or a registered nurse, other than the attending nurse practitioner, who provides direct care to the patient may record the review in the medical record at the direction of the physician. In such case, the attending practitioner shall include a confirmation of the review in the patient's medical record within fourteen days of such review. Failure to comply with this subdivision shall not render a nonhospital order not to resuscitate ineffective.

5. A person who has consented to a nonhospital order not to resuscitate may at any time revoke his or her consent to the order by any act evidencing a specific intent to revoke such consent. Any health care professional, other than the attending practitioner, informed of a revocation of consent to a nonhospital order not to resuscitate shall

notify the attending practitioner of the revocation. An attending practitioner who is informed that a nonhospital order not to resuscitate has been revoked shall record the revocation in the patient's medical record, cancel the order and make diligent efforts to retrieve the form issuing the order, and the standard bracelet, if any.

6. The commissioner may authorize the use of one or more alternative forms for issuing a nonhospital order not to resuscitate (in place of the standard form prescribed by the commissioner under subdivision two of this section). Such alternative form or forms may also be used to issue a non-hospital do not intubate order. Any such alternative forms intended for use for persons with developmental disabilities or persons with mental illness who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to article eighty-one of the mental hygiene law or article seventeen-A of the surrogate's court procedure act must also be approved by the commissioner of developmental disabilities or the commissioner of mental health, as appropriate. An alternative form under this subdivision shall otherwise conform with applicable federal and state law. This subdivision does not limit, restrict or impair the use of an alternative form for issuing an order not to resuscitate in a general hospital or residential health care facility under article twenty-eight of this chapter or a hospital under subdivision ten of section 1.03 of the mental hygiene law or a facility certified or operated by the office for people with developmental disabilities.

§ 2994-ee. Obligation to honor a nonhospital order not to resuscitate. Emergency medical services personnel, home care services agency personnel, hospice personnel, or hospital emergency services personnel who are provided with a nonhospital order not to resuscitate, or who identify the standard bracelet on the patient's body, shall comply with the terms of such order; provided, however, that:

1. Emergency medical services personnel, home care services agency personnel, hospice personnel, or hospital emergency services personnel may disregard the order if:

(a) They believe in good faith that consent to the order has been revoked, or that the order has been cancelled; or

(b) Family members or others on the scene, excluding such personnel, object to the order and physical confrontation appears likely; and

2. Hospital emergency services physicians and hospital emergency services nurse practitioners and physician assistants may direct that the order be disregarded if other significant and exceptional medical circumstances warrant disregarding the order.

§ 2994-ff. Interinstitutional transfer. If a patient with a nonhospital order not to resuscitate is admitted to a hospital, or if a hospital patient with an order not to resuscitate is transferred from a hospital to a different hospital, the order shall be treated as an order not to resuscitate for a patient transferred from another hospital, and shall be governed by section twenty-nine hundred ninety-four-l of this chapter.

§ 2994-gg. Immunity. No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this article a nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this article.

ARTICLE 29-CCCC

CARE ACT (CAREGIVER ADVISE, RECORD AND ENABLE ACT)

Section 2994-hh. Short title.

2994-ii. Definitions.

2994-jj. Caregiver; opportunity to identify.

2994-kk. Notice to identified caregiver.

2994-ll. Instruction to identified caregiver.

2994-mm. Effect on other rights.

§ 2994-hh. Short title. This article shall be known and may be cited as the "CARE act".

§ 2994-ii. Definitions. When used in this article, the following words or phrases shall have the following meanings:

1. "Hospital" shall mean any "general hospital" as defined in section twenty-eight hundred one of this chapter.

2. "After-care" shall mean any assistance provided by a caregiver to a patient under this article after the patient's discharge from a hospital that is related to the patient's condition at the time of discharge. Such assistance shall include, but is not limited to, assisting with basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), and other tasks as determined to be appropriate by the discharging physician.

3. "Caregiver" shall mean any individual duly identified as a caregiver by a patient under this article who provides after-care assistance to a patient living in his or her residence. An identified caregiver shall include, but is not limited to, a relative, partner, friend or neighbor who has a significant relationship with the patient.

4. "Discharge" shall mean a patient's exit or release from a hospital to the patient's residence following an inpatient admission.

5. "Entry" shall mean a patient's admission into a hospital for the purposes of receiving inpatient care.

6. "Patient" shall mean a patient eighteen years of age or older.

7. "Residence" shall mean a dwelling that the patient considers to be his or her home. A "residence" for the purposes of this article shall not include any rehabilitation facility, hospital, nursing home,

assisted living facility, group home or other residential health care facility as defined in section twenty-eight hundred one of this chapter or any inpatient facility regulated by the office of mental health.

§ 2994-jj. Caregiver; opportunity to identify. 1. A hospital shall provide each patient or, if applicable, the patient's legal guardian with at least one opportunity to identify at least one caregiver under this article following the patient's entry into a hospital and prior to the patient's discharge or transfer to another facility. The hospital shall inform the patient that the purpose of providing the caregiver's identity is to include that caregiver in discharge planning and sharing of post-discharge care information or instruction.

(a) In the event that the patient is unconscious or otherwise incapacitated upon his or her entry into a hospital, the hospital shall provide such patient or his/her legal guardian with an opportunity to identify a caregiver following the patient's recovery of his or her consciousness or capacity.

(b) In the event that the patient or the patient's legal guardian declines to identify a caregiver under this article, the hospital shall promptly document this in the patient's medical record.

(c) The hospital shall record the patient's identification of a caregiver if given by the patient or legal guardian, the relationship of the identified caregiver to the patient, and the name, telephone number, and address of the patient's identified caregiver in the patient's medical record.

(d) A patient may elect to change his or her identified caregiver at any time, and the hospital must record this change in the patient's medical record.

(e) (i) The hospital shall promptly request the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated caregiver following the hospital's established procedure for releasing personal health information and in compliance with all state and federal laws, including the federal Health Insurance Portability and Accountability Act of 1996 as amended, and related regulations.

(ii) If the patient or the patient's legal guardian declines to

consent to release medical information to the patient's designated caregiver, the hospital shall not be required to provide notice to the caregiver under section twenty-nine hundred ninety-four-kk of this article or provide information contained in the patient's discharge plan under section twenty-nine hundred ninety-four-ll of this article.

2. An identification of a caregiver by a patient or a patient's legal guardian under this section does not obligate any individual to perform any after-care tasks for any patient.

3. This section shall not be construed to require a patient or a patient's legal guardian to identify any individual as a caregiver as defined by this article.

§ 2994-kk. Notice to identified caregiver. A hospital shall notify the patient's identified caregiver of the patient's discharge or transfer to another hospital or facility licensed by the department or the office of mental health as soon as the date and time of discharge or transfer can be anticipated prior to the patient's actual discharge or transfer to such facility. In the event the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital shall promptly document the attempt in the patient's medical record.

§ 2994-ll. Instruction to identified caregiver. 1. As soon as possible and not later than twenty-four hours prior to a patient's discharge from a hospital, the hospital shall consult with the identified caregiver along with the patient regarding the caregiver's capabilities and limitations and issue a discharge plan that describes a patient's after-care needs at his or her residence. In the event the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. In the event that the identified caregiver is unwilling or unable to confidently

provide proper care, the hospital shall assess whether other services, including but not limited to home care services, are needed and, if necessary, order such services. The hospital shall promptly document the attempt in the patient's medical record. At minimum, a discharge plan shall include:

- (a) the name and contact information of the caregiver identified under this article;

- (b) a description of all after-care tasks recommended by the discharging physician, taking into account the capabilities and limitations of the caregiver; and

- (c) contact information for health care, community resources, and long-term services and supports necessary to successfully carry out the patient's discharge plan.

2. The hospital issuing the discharge plan must offer caregivers with instruction in all after-care tasks described in the discharge plan.

- (a) At minimum, such instruction shall include:

- (i) a live or recorded demonstration of the tasks performed by a hospital employee authorized to perform the after-care task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law;

- (ii) an opportunity for the caregiver and patient to ask questions about the after-care tasks; and

- (iii) answers to the caregiver's and patient's questions provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law.

- (b) Any instructions required under this article shall be documented in the patient's medical record, including, at minimum, the date, time, and contents of the instruction.

3. The department is authorized to promulgate regulations to implement the provisions of this article, including but not limited to, regulations to further define the content and scope of any instruction provided to caregivers under this article.

§ 2994-mm. Effect on other rights. 1. Nothing in this article shall be construed to interfere with the rights of an agent operating under a valid health care directive created under section twenty-nine hundred eighty-two of this chapter.

2. Nothing in this article shall be construed to create a new private right of action not otherwise existing in law against a hospital or any of its directors, trustees, officers, employees or agents, or any contractors with whom a hospital has a contractual relationship.

3. A hospital, any of its directors, trustees, officers, employees or agents, or any contractors with whom a hospital has a contractual relationship shall not be held liable, provided it has complied with this article and acted reasonably and in good faith, for the services rendered or not rendered by the caregiver to the patient at the patient's residence.

ARTICLE 29-D

HEALTH INFORMATION AND QUALITY IMPROVEMENT

TITLE 1

HEALTH INFORMATION

- | | |
|---------------|--|
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§ 2995. Structure and definitions. 1. Structure. * (a) The department shall undertake an initiative for the purposes of increasing the information available to patients about health care providers and health care plans, and improving the quality of health care in this state, by creating a statewide health information system, collecting health information for dissemination by means of such system, and studying

additional uses of such information. Such moneys as may be necessary to effect the purpose of this section may be appropriated to the department for its expenses.

* NB Effective until March 31, 2029

* (a) The department shall undertake an initiative for the purposes of increasing the information available to patients about health care providers and health care plans, and improving the quality of health care in this state, by creating a statewide health information system, collecting health information for dissemination by means of such system, and studying additional uses of such information. Such moneys as may be necessary to effect the purpose of this section may be appropriated to the department for its expenses, but in no event shall funds be diverted from existing uses of the office of professional medical conduct in order to fulfill the purposes of this section.

* NB Effective March 31, 2029

(b) The department shall promulgate rules for the purpose of implementing the provisions of this title.

2. Definitions. For the purposes of this title:

(a) "Health care plan" shall mean a health maintenance organization, as defined by subdivision one of section forty-four hundred one of this chapter, a health service corporation licensed pursuant to article forty-three of the insurance law, a prepaid health services plan licensed pursuant to section forty-four hundred three-a of this chapter, or an integrated delivery system licensed pursuant to section forty-four hundred eight-a of this chapter.

(b) "Health information" shall mean physician data, hospital data, and health care plan data, to the extent such data is disclosable pursuant to any provision of law. Such term shall not include individual patient data, except to the extent such data is disclosable pursuant to any other provision of law.

(c) "Individual patient data" shall mean any information concerning an individual patient, whether held orally or recorded in any form or medium, including, but not limited to, information derived from a biological sample from the patient, the sample itself or genetic information that:

(i) relates to the physical or mental health of the patient, the

provision of health care to the patient, or the payment for the provision of health care to the patient; and

(ii) (A) identifies the individual patient;

(B) could foreseeably be used or manipulated to identify the individual patient; or

(C) could foreseeably be linked or matched to any other information described in clause (A) or (B) of this subparagraph.

(d) "Statewide health information system" shall mean a collection of health information to be publicly available on an ongoing basis for the purpose of making statewide comparisons.

(e) "Preferred provider organization data" shall mean data collected from an insurance company subject to article thirty-two of the insurance law, a corporation subject to article forty-three of the insurance law, or a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, with respect to preferred provider organization (PPO) products, as defined by the commissioner in consultation with the superintendent, offered by such entities.

(f) "Health care practitioner" shall mean a physician, nurse practitioner, or physician assistant licensed or certified pursuant to title eight of the education law.

(g) "Sudden unexpected death in epilepsy" shall mean sudden, unexpected death in patients with epilepsy, with or without evidence of a seizure.

§ 2995-a. Physician profiles. 1. The department shall collect the following information and create individual profiles on licensees subject to the authority of the office of professional medical conduct, in a format that shall be available for dissemination to the public:

(a) a statement of any criminal convictions (as defined by section 1.20 of the criminal procedure law) within the most recent ten years, under the laws of New York state or any other jurisdiction, for offenses specified by regulations of the department;

(b) a statement of any action (other than an action that remains confidential) taken against the licensee pursuant to section two hundred thirty of this chapter or any similar action taken by any other state or licensing entity, within the most recent ten years;

(c) a statement of any current limitation of the licensee to a specified area, type, scope or condition of practice;

(d) a statement of any loss or involuntary restriction of hospital privileges or a failure to renew professional privileges at hospitals within the last ten years, for reasons related to the quality of patient care delivered or to be delivered by the physician where procedural due process has been afforded, exhausted, or waived, or the resignation from or removal of medical staff membership or restriction of privileges at a hospital taken in lieu of a pending disciplinary case related to the quality of patient care delivered or to be delivered by the physician (notwithstanding paragraph (a) of subdivision three of section twenty-eight hundred three-e of this chapter, as added by chapter eight hundred sixty-six of the laws of nineteen hundred eighty);

(e) (i) a statement indicating the number of medical malpractice court judgments and arbitration awards within the most recent ten years in which a payment is awarded to a complaining party (notwithstanding subsection (f) of section three hundred fifteen of the insurance law); and

(ii) a statement indicating all malpractice settlements within the most recent ten years in which payment is awarded to a complaining party (notwithstanding subsection (f) of section three hundred fifteen of the insurance law),

(A) if the total number of settlements exceeds two; or

(B) if the commissioner determines any such settlement could be relevant to patient decisionmaking concerning health care quality. The statement shall include the following: "Settlement payments will appear in this profile only if the total number of settlements made within the past ten years exceeds two, or if the commissioner of health determines a settlement to be relevant to patient decisionmaking. Settlement of a claim may occur for a variety of reasons, which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim does not necessarily mean that a medical malpractice has occurred." The commissioner may supplement such statement as may be appropriate.

(iii) judgments, awards and settlements shall be reported in graduated categories indicating the level of significance, date and place of the

judgment, award or settlement. Information concerning medical malpractice judgments, awards and settlements shall be put in context by comparing an individual licensee's medical malpractice settlements to the experience of other physicians in New York state within the same board specialty. Pending malpractice claims shall not be disclosed to the public under this section. Nothing herein shall be construed to prevent the board from investigating or disciplining a licensee on the basis of medical malpractice claims that are pending;

- (f) name of medical schools attended and date of graduations;

- (g) graduate medical education;

- (h) current specialty board certification and date of certification;

- (i) dates admitted to practice in New York state;

- (j) names of hospitals where the licensee has practice privileges;

- (k) appointments to medical school faculties and indication as to whether a licensee has had a responsibility for graduate medical education within the most recent ten years;

- (l) information regarding publications in peer reviewed medical literature within the most recent ten years;

- (m) information regarding professional or community service activities or awards;

- (n) (i) the location of the licensee's primary practice setting identified as such; and

- (ii) the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter;

- (o) the identification of any translating services that may be available at the licensee's primary practice location;

- (p) whether the licensee participates in the medicaid or medicare program or any other state or federally financed health insurance program; and

- (q) health care plans with which the licensee has contracts, employment, or other affiliation; provided that the reporting of such information shall not be the responsibility of the physician, but shall be included and updated by the department utilizing provider network participation information, or other reliable sources of information submitted by health care plans.

1-a. Each physician licensed and registered to practice in this state shall within thirty days of the transmittal of an initial profile survey and upon entering or updating his or her profile information:

(a) register and maintain an account with the department's health provider network and any successor electronic system established to facilitate communications between the department and licensed health care providers; or

(b) provide an e-mail address to the department which shall be used by the department to communicate with the physician. Licensees shall provide notice to the department of changed e-mail addresses within thirty days of the change. Licensee e-mail addresses shall be confidential and shall not be published as part of the licensee's profile. The e-mail addresses may be used for department purposes only.

2. Nothing in this section shall limit the department's authority to collect, require reporting of, publish or otherwise disseminate information about licensees.

3. Each physician who is self-insured for professional medical malpractice shall periodically report to the department on forms and in the time and manner required by the commissioner the information specified in paragraph (e) of subdivision one of this section, except that the physician shall report the dollar amount (to the extent of the physician's information and belief) for each judgment, award and settlement and not a level of significance or context.

4. Each physician shall periodically report to the department on forms and in the time and manner required by the commissioner any other information as is required by the department for the development of profiles under this section which is not otherwise reasonably obtainable. In addition to such periodic reports and providing the same information, each physician shall update his or her profile information within the six months prior to the submission of the re-registration application, as a condition of registration renewal under article one hundred thirty-one of the education law. Except for optional information provided, physicians shall notify the department of any change in the profile information within thirty days of such change.

5. The department shall provide each licensee with a copy of his or her profile prior to dissemination to the public. In the manner and time required by the commissioner, a licensee shall be provided the opportunity to correct factual inaccuracies that appear in the profile. The physician shall be permitted to file a concise statement concerning information contained in the profile, which shall be disseminated therewith.

6. A physician may elect to have his or her profile omit certain information provided pursuant to paragraphs (l), (m) and (n) of subdivision one of this section. In collecting information for such profiles and disseminating the same, the department shall inform physicians that they may choose not to provide such information required pursuant to paragraphs (l), (m) and (n) of subdivision one of this section.

7. A physician who knowingly provides materially inaccurate information under this section shall be guilty of professional misconduct pursuant to section sixty-five hundred thirty of the education law.

7-a. For purposes of this section, a physician may authorize a designee to register, transmit, enter or update information on his or her behalf, provided that:

(a) the designee so authorized is employed by the physician or the same professional practice or is under contract with such practice;

(b) the physician takes reasonable steps to ensure that such designee is sufficiently competent in the profile requirements; and

(c) the physician remains responsible for ensuring the accuracy of the information provided and for any failure to provide accurate information.

The commissioner shall establish in regulation reasonable parameters with regard to a physician's ability to authorize designees pursuant to this section, which shall include processes necessary to allow the department to: (i) grant access to the profile in a reasonably prompt

manner to designees authorized by physicians; (ii) require that physicians notify the department upon terminating the authorization of any designee; and (iii) establish a mechanism to prevent such terminated designees from accessing the profile in a reasonably prompt manner following such notification.

8. The department shall establish a toll-free telephone number through which it shall answer inquiries about and accept orders for hard copy physician profiles established pursuant to this section and accept consumer complaints about suspected professional misconduct. The department may charge a nominal fee for producing and mailing a hard copy physician profile.

9. The department shall, in addition to hard copy physician profiles, provide for electronic access to and copying of physician profiles developed pursuant to this section through the system commonly known as the Internet. The department shall update a physician's online profile within thirty days of receipt of a completed physician profile survey or any change in profile information.

10. The commissioner shall require that:

(a) Practitioner organizations that are representative of the target group for profiling, and health care consumer organizations, be provided the opportunity to review and comment on the profiling methodology, including collection methods, analysis, formatting, and methods and means for release and dissemination.

(b) Comparisons of practitioner profiles shall be organized according to practitioner areas of practice.

11. The commissioner shall evaluate the utility and practicability of including in the profile a comparison of malpractice data by geographic area. However, the implementation of the profile shall not be delayed pending such evaluation.

12. The commissioner shall develop and distribute a notice suitable for posting that informs consumers of the availability of physician profiles and the telephone numbers and Internet addresses for accessing

them.

13. Further study of physician profiles. After the initial dissemination of the data identified in subdivision one of this section, the department shall conduct a further study of physician profiles as follows:

(a) Data sources. The department shall identify the types of physician data to which the public has access, including all information available from federal, state or local agencies which is useful for making determinations concerning health care quality determinations. The department shall study all physician data reporting requirements and develop recommendations to consolidate data collection and eliminate duplicate and unnecessary reporting requirements, or to supplement existing reporting requirements in order to satisfy the requirements of this section. The department shall study the feasibility of incorporating health plan reporting requirements, without imposing any extra burden on the physician, regarding network participation into this section to ensure this information is available, accurate, up-to-date and accessible to consumers.

(b) Supplemental information adjustment and security safeguards. The department shall develop a methodology for application to collected physician data that accounts for factors such as frequency, severity and geographic area which shall be used to provide context to reported data. Any such methodology shall not diminish the information reported pursuant to subdivision one of this section. In developing such methodology, the department may consult with physicians, including representatives of appropriate specialty societies. The department may also consult with organizations representing consumers, other health care providers, and health care plans. Any such methodology shall include adequate and appropriate safeguards to ensure the security, accuracy and integrity of health information created, received, maintained, used or transmitted in connection with the statewide health information system. Such safeguards shall be sufficient to meet any minimum standards set by state and federal laws and regulations.

(c) Public review. The department shall provide organizations which are representative of consumers, physicians, including representatives of appropriate specialty societies, other health care providers and

health care plans the opportunity to review and comment on its determinations and recommendations. The department shall consider such comments, and may amend its determinations and recommendations to reflect them.

(d) Report. The department shall provide a report of its determinations and recommendations under this subdivision to the governor and legislature, and make such report publicly available, on or before January first, two thousand sixteen. The department shall report annually thereafter to the legislature on the status of the physician profiles and any recommendations for additions, consolidations or other changes deemed appropriate.

14. The physician data so disseminated shall be updated at regular intervals to be determined by the department.

15. (a) All physician data disseminated shall include the following statements: "THE DATA COLLECTED BY THE DEPARTMENT IS ACCURATE TO THE BEST OF THE KNOWLEDGE OF THE DEPARTMENT, BASED ON THE INFORMATION SUPPLIED BY THE PHYSICIAN WHO IS THE SUBJECT OF THE DATA. WHILE THE DEPARTMENT UTILIZES A VARIETY OF SOURCES OF INFORMATION IN CHECKING THE ACCURACY OF THE DATA REPORTED, WE CANNOT BE SURE THAT ALL OF THE INFORMATION ON THIS WEBSITE IS RIGHT, COMPLETE, OR UP-TO-DATE, AND CANNOT BE RESPONSIBLE FOR ANY INFORMATION THAT IS WRONG OR HAS BEEN LEFT OUT. CONSUMERS ARE ENCOURAGED TO CONSULT OTHER SOURCES TO VERIFY OR OBTAIN ADDITIONAL INFORMATION ABOUT A PHYSICIAN. PENDING LEGAL ACTIONS DO NOT IN ANY WAY INDICATE PARTIES' GUILT, LIABILITY OR CULPABILITY. CASES MAY BE DISMISSED, WITHDRAWN, OR SETTLED WITHOUT PAYMENTS TO PLAINTIFFS. ANY DISPOSITION TO A CASE MAY BE SUBJECT TO APPEAL." The commissioner shall ensure that the full text of the statements appear on each web page of the physician profile in a manner that does not require the user of the site to click on a separate link in order to view the statements.

(b) The department shall provide on the physician profiles an active link to the website maintained by the unified court system containing information on active and disposed cases in the local and state courts in the state.

16. If, after initial dissemination of the physician data required by this section, the department determines that any such data is not useful for making quality determinations, the department shall recommend to the legislature the necessary statutory changes.

§ 2995-b. Hospital report cards. 1. Collection. The department shall collect the following hospital data for dissemination to inform consumer decisionmaking via a statewide health information system:

(a) Utilization and performance information to promote quality improvement activities which was collected and evaluated for appropriate dissemination pursuant to subparagraph (ii) of paragraph (a) of subdivision one of the former section twenty-eight hundred seven-n of this chapter, as added by section sixty of chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six;

(b) Statewide performance data comparing utilization and selected performance measures to accepted norms and/or benchmarks developed by recognized experts, which were developed pursuant to subparagraph (iii) of paragraph (a) of subdivision one of the former section twenty-eight hundred seven-n of this chapter, as added by section sixty of chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six; and

(c) Other hospital data, if any, collected for public dissemination by the state task force on health care quality improvement pursuant to the former section twenty-eight hundred four-b of this chapter, as added by section sixty-a of chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six.

2. Preparation of data and public review. The department shall thereafter prepare and risk-adjust as appropriate the collected hospital data for dissemination pursuant to the former subparagraph (iii) of paragraph (c) of subdivision two of section twenty-eight hundred four-b of this chapter, as added by section sixty-a of chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six. The department shall coordinate its efforts with programs of the national forum for health care quality measurement and reporting (quality forum). The department shall provide each hospital with a copy of the hospital data to be disseminated concerning it. In a manner and time required by the

department, the hospital shall be provided with an opportunity to correct factual inaccuracies, and to file a statement in a form prescribed by the department concerning the data, which statement shall be disseminated with such data.

3. Dissemination. The department shall thereafter disseminate the collected hospital data, with corrections and statements, if any.

(a) Thereafter, the hospital data so disseminated shall be updated at regular intervals to be determined by the department.

(b) All hospital data disseminated shall include the following statement: "THE DATA COLLECTED BY THE DEPARTMENT IS ACCURATE TO THE BEST OF THE KNOWLEDGE OF THE DEPARTMENT, BASED ON THE INFORMATION SUPPLIED BY THE HOSPITAL WHICH IS THE SUBJECT OF THE DATA."

(c) If the department determines that any data to be disseminated pursuant to this section is not useful for making quality determinations, the department shall recommend to the legislature the necessary statutory changes.

§ 2995-c. Health care plan and preferred provider organization data.

1. Collection. The department shall collect for dissemination via a statewide health information system, any health care plan and preferred provider organization data collected for public dissemination pursuant to the quality assurance reporting requirements developed by the department in conjunction with the national committee on quality assurance.

2. Preparation of data and public review. The department shall thereafter prepare the collected health care plan and preferred provider organization data for dissemination. The department shall provide each health care plan with a copy of the health care plan and preferred provider organization data to be disseminated concerning it. In a manner and time required by the department, the health care plan shall be provided with an opportunity to correct factual inaccuracies, and to file a statement in a form prescribed by the department concerning the data, which statement shall be disseminated with the data.

3. Dissemination. The department shall thereafter disseminate the collected health care plan and preferred provider organization data, organized and segregated by type of product and type of organization offering the product, with corrections and statements, if any. The department shall share preferred provider organization data with the superintendent of financial services.

(a) Thereafter, the health care plan and preferred provider organization data so disseminated shall be updated at regular intervals to be determined by the committee.

(b) All health care plan and preferred provider organization data disseminated shall include the following statement: "THE DATA COLLECTED BY THE DEPARTMENT IS ACCURATE TO THE BEST OF THE KNOWLEDGE OF MEMBERS AND STAFF, BASED ON THE INFORMATION SUPPLIED BY THE HEALTH CARE PLAN WHICH IS THE SUBJECT OF THE DATA."

(c) If the department determines that any data to be disseminated pursuant to this section is not useful for determinations concerning health care quality, the department shall recommend to the legislature the necessary statutory changes.

§ 2995-d. Further study of other health care practitioner data. The department shall:

1. Identify the classes of health care practitioners licensed, certified or registered pursuant to title eight of the education law, concerning whom it would be feasible and useful to collect and disseminate information useful for making determinations concerning health care quality;

2. Investigate the types of data concerning such practitioners to which the public has access, including all information provided by federal, state or local agencies, and the applicable data reporting requirements;

3. Determine which data concerning such practitioners and which methods of accessing such data, will be the most useful and convenient for health care consumers;

4. Study the feasibility and utility of providing practitioner profiles by means of the system commonly known as the Internet, on a single website; and

5. Provide a report of its findings to the governor and legislature within eighteen months of the effective date of this section.

§ 2996. Study of physician credentialing. 1. The department shall examine the feasibility of establishing a clearinghouse for credentialing information to reduce the burden for physicians required to submit credentials to entities licensed and regulated by the state. As part of such examination, the department shall:

(a) examine the efficacy of the credentialing process prescribed by section twenty-eight hundred five-j of this chapter;

(b) determine which methods of organizing such a clearinghouse with standardized data in a standardized format will provide the greatest usability and convenience to health care providers and health care plans;

(c) identify the most appropriate entity to administer such a clearinghouse, and verify collected credential information; and

(d) identify safeguards to protect the privacy of providers participating in such a credentialing system.

2. The department shall provide a report of its findings and recommendations to the governor and legislature within eighteen months of the effective date of this section.

§ 2997. Patient privacy. 1. The department shall examine state laws protecting the privacy of individual patient data, and determine the necessity of supplementing existing protections.

2. The department shall examine federal initiatives protecting the privacy of individual patient data, and such federal initiatives' potential preemptive effect on state law protections.

3. The department shall provide a report of its findings to the governor and the legislature within eighteen months of the effective date of this section.

§ 2997-a. Public access. Nothing in this title shall abridge public access to information currently available or permitted by any other provision or rule of law. Nothing in this title shall not authorize the disclosure of otherwise confidential information, except pursuant to the express terms of this title.

§ 2997-b. Pamphlet of department programs. The commissioner shall develop and transmit to physicians in the state a pamphlet describing a variety of department programs and initiatives, including but not limited to smoking cessation programs, public health insurance programs, health and quality improvement information, the patient safety center and physician profiles. Each physician practicing in the state shall make the pamphlet available in his or her practice reception area so that it is accessible to patients.

§ 2997-c. Palliative care patient information. 1. Definitions. As used in this section, the following terms shall have the following meanings, unless the context clearly requires otherwise:

(a) "Appropriate" means consistent with applicable legal, health and professional standards; the patient's clinical and other circumstances; and the patient's reasonably known wishes and beliefs.

(b) "Attending health care practitioner" means a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient. Where more than one physician or nurse practitioner share that responsibility, each of them has responsibility under this section, unless they agree to assign that responsibility to one of them.

(c) "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance

the patient's quality of life, including hospice care under article forty of this chapter.

(d) "Terminal illness or condition" means an illness or condition which can reasonably be expected to cause death within six months, whether or not treatment is provided.

2. If a patient is diagnosed with a terminal illness or condition, the patient's attending health care practitioner shall offer to provide the patient with:

(a) information and counseling regarding palliative care and end-of-life options appropriate to the patient, including but not limited to: the range of options appropriate to the patient; the prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management at the end of life, and

(b) information regarding other appropriate treatment options should the patient wish to initiate or continue treatment. The information and counseling may be provided orally or in writing. Where the patient lacks capacity to reasonably understand and make informed choices relating to palliative care, the attending health care practitioner shall provide information and counseling under this section to a person with authority to make health care decisions for the patient. The attending health care practitioner may arrange for information and counseling under this section to be provided by another professionally qualified individual, and

(c) information and counseling regarding benefits of completing a health care proxy and appointing a health care agent. A copy of the newly completed or existing health care proxy shall be requested by the health care practitioner and made a part of the patient's medical record.

3. Where the attending health care practitioner is not willing or does not feel qualified to provide the patient with information and counseling under this section, he or she shall arrange for another physician or nurse practitioner to do so, or shall refer or transfer the patient to another physician or nurse practitioner willing to do so.

§ 2997-d. Hospital, nursing home, home care, special needs assisted living residences and enhanced assisted living residences palliative care support. 1. (a) "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

(b) "Appropriate" has the same meaning as paragraph (a) of subdivision one of section twenty-nine hundred ninety-seven-c of this title.

2. General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article forty-six-B of this chapter shall establish policies and procedures to provide patients with advanced life limiting conditions and illnesses who might benefit from palliative care, including associated pain management, services with access to information and counseling regarding such options appropriate to the patient. Policies must include provision for patients who lack capacity to make medical decisions, so that access to such information and counseling shall be provided to the persons who are legally authorized to make medical decisions on behalf of such patients.

3. General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article forty-six-B of this chapter shall facilitate access to appropriate palliative care consultations and services, including associated pain management consultations and services, including but not limited to referrals consistent with patient needs and preferences. The department shall take into account access and proximity of palliative care services, including the availability of hospice and palliative care board certified practitioners and other related workforce staff, geographic factors, and facility size that may impact development of palliative care services.

§ 2997-e. Provision of contact information relating to long term care.

Whenever a health care provider or practitioner makes a recommendation regarding the necessity of long term care services or a referral for the receipt of long term care services to a patient, the patient or patient's designated representative shall be provided by the health care provider or practitioner the contact information for NY Connects: Choices for Long Term Care, established pursuant to subdivision eight of section two hundred three of the elder law, that corresponds to the patient's county of residence or prospective county of residence based on the preference of the patient.

§ 2997-f. Provision of information relating to aging services.

Whenever a hospital is discharging an individual aged sixty years of age or older, the hospital's discharge coordinator shall provide such individual with a copy of the information provided to them pursuant to subdivision eleven of section two hundred three of the elder law that corresponds to the individual's county of residence.

§ 2997-f-1. Provision of information relating to sudden unexpected death in epilepsy. 1. Any health care practitioner who is treating a patient diagnosed with epilepsy and at elevated risk for sudden unexpected death in epilepsy, who has primary responsibility for the treatment and care of the patient for epilepsy, other than a health care practitioner treating such patient in an emergency situation, shall provide such patient with the following written information:

(a) current and evidence-based information about sudden unexpected death in epilepsy risk factors and conditions reviewed and approved by one or more professional not-for-profit organizations with expertise in neurology and epilepsy; and

(b) contact information for nonprofit organizations that provide information and support services for epilepsy conditions.

2.(a) The commissioner shall provide written information to health care practitioners necessary to implement subdivision one of this

section, and shall post such information on the department's website.

(b) The commissioner shall ensure that such information is culturally and linguistically appropriate for all recipients.

(c) Any local or national organization that provides education or services related to epilepsy conditions may request that the commissioner include such organization's informational material and contact information on the department's website. Once such a request is made, the commissioner may add the information to the department's website at his or her discretion.

(d) The commissioner shall, in consultation with local and national organizations that provide education or services related to epilepsy conditions, provide guidance to health care practitioners to assist health care practitioners in determining whether a patient is at elevated risk for sudden unexpected death in epilepsy, including but not limited to, whether the patient has had convulsive seizures, the frequency and recency of such seizures, and whether the patient's symptoms have subsided in response to medicinal or surgical treatment.

3. A health care practitioner found to be in violation of this section shall be issued a warning and shall suffer no further civil penalty or discipline on any first offense, provided such violation was not committed willfully and knowingly.

TITLE 1-A

SAFE PATIENT HANDLING

Section 2997-g. Legislative intent.

2997-h. Definitions.

2997-i. Safe patient handling workgroup.

2997-j. Dissemination of best practices, examples of sample safe patient handling policies and other resources and tools.

2997-k. Safe patient handling committees; programs.

2997-l. Activities.

§ 2997-g. Legislative intent. The legislature hereby finds and

declares that it is in the public interest for health care facilities to implement safe patient handling policies. There are many benefits that can be derived from safe patient handling programs. Patients benefit through improved quality of care and quality of life by reducing the risk of injury. Caregivers also benefit from the reduced risk of career ending and debilitating injuries leading to increased morale, improved job satisfaction, and longevity in the profession. Health care facilities may realize a return on their investment through reduced workers' compensation medical and indemnity costs, reduced lost workdays, and improved recruitment and retention of caregivers. All of this could lead to fiscal improvement in health care in New York State.

§ 2997-h. Definitions. For the purposes of this title:

1. "Health care facility" shall mean general hospitals, residential health care facilities, diagnostic and treatment centers, and clinics licensed pursuant to article twenty-eight of this chapter, facilities which provide health care services and are licensed or operated pursuant to article eight of the education law, article nineteen-G of the executive law or the correction law, and hospitals and schools defined in section 1.03 of the mental hygiene law.

2. "Nurse" shall mean a registered professional nurse or a licensed practical nurse as defined by article one hundred thirty-nine of the education law.

3. "Direct care worker" shall mean any employee of a health care facility who is responsible for patient handling or patient assessment as a regular or incidental part of his or her employment, including any licensed or unlicensed health care worker.

4. "Employee representative" shall mean the recognized or certified collective bargaining agent for nurses or direct care workers of a health care facility.

5. "Safe patient handling" shall mean the use of engineering controls,

lifting and transfer aids, or assistive devices by staff to perform the acts of lifting, transferring and repositioning health care patients and residents.

6. "Musculoskeletal disorders" shall mean conditions that involve the nerves, tendons, muscles and supporting structures of the body.

§ 2997-i. Safe patient handling workgroup. 1. The commissioner shall establish a safe patient handling workgroup (referred to in this section as the "workgroup") within the department. The workgroup shall consist of, at the minimum, the commissioner or his or her designee; the commissioner of labor or his or her designee; representatives of health care provider organizations; representatives from employee organizations representing nurses and representatives from employee organizations representing direct care workers; representatives of nurse executives; representatives who are certified ergonomist evaluation specialists; and representatives who have expertise in fields of discipline related to health care or occupational safety.

2. Workgroup members shall receive no compensation for their services as members of the workgroup, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

3. The workgroup shall be established no later than January first, two thousand fifteen.

4. The workgroup shall:

(a) Review existing safe patient handling programs or policies, including demonstration programs previously authorized by chapter seven hundred thirty-eight of the laws of two thousand five and national data and results;

(b) Consult with any organization, educational institution, other government entity or agency or person that the workgroup determines may be able to provide information and expertise on the development and implementation of safe patient handling programs;

(c) Identify or develop training materials for consideration by health

care facilities; and

(d) Submit a report to the commissioner by July first, two thousand fifteen identifying safe patient handling program best practices, providing examples of sample policies, and identifying resources and tools useful for providers to meet the goals of safe patient handling policies.

5. All state departments, commissions, agencies, and public authorities shall provide the workgroup with any reasonably requested assistance or advice in a timely manner.

§ 2997-j. Dissemination of best practices, examples of sample safe patient handling policies and other resources and tools. The commissioner shall disseminate best practices, examples of sample safe patient handling policies, and other resources and tools to health care facilities, taking into consideration the recommendations of the safe patient handling workgroup. Such best practices, examples of sample safe patient handling policies, and other resources and tools shall be made available to all facilities covered by this title on or before January first, two thousand sixteen.

§ 2997-k. Safe patient handling committees; programs. 1. On or before January first, two thousand sixteen, each health care facility shall establish a safe patient handling committee (referred to in this section as a "committee" except where the context clearly requires otherwise) either by creating a new committee or assigning the functions of a safe patient handling committee to an existing committee, including but not limited to a safety committee or quality assurance committee, or subcommittee thereof. The purpose of a committee is to design and recommend the process for implementing a safe patient handling program for the health care facility. The committee shall include individuals with expertise or experience that is relevant to safe patient handling, including risk management, nursing, purchasing, or occupational safety and health, and in facilities where there are employee representatives, at least one shall be appointed on behalf of nurses and at least one

shall be appointed on behalf of direct care workers. One half of the members of the committee shall be frontline non-managerial employees who provide direct care to patients. At least one non-managerial nurse and one non-managerial direct care worker shall be on the safe patient handling committee. In health care facilities where a resident council is established, and where feasible, at least one member of the safe patient handling committee shall be a representative from the resident council. The committee shall have two co-chairs with one from management and one frontline non-managerial nurse or direct care worker.

2. On or before January first, two thousand seventeen, each health care facility, in consultation with the committee, shall establish a safe patient handling program. As part of this program, a health care facility shall:

(a) implement a safe patient handling policy, considering the elements of the sample safe patient handling policies and best practices disseminated by the commissioner, as well as the type of facility and its services, patient populations and care plans, types of caregivers, and physical environment, for all shifts and units of the health care facility. Implementation of the safe patient handling policy may be phased-in;

(b) conduct a patient handling hazard assessment. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations and the physical environment of patient care areas;

(c) develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of safe patient handling equipment. The policy shall include a means to address circumstances under which it would be contraindicated based on a patient's physical, medical, weight-bearing, cognitive and/or rehabilitative status to use lifting or transfer aids or assistive devices for particular patients;

(d) provide initial and on-going yearly training and education on safe patient handling for current employees and new hires, and establish procedures to ensure that retraining for those found to be deficient is provided as needed;

(e) set up and utilize a process for incident investigation and

post-investigation review which may include a plan of correction and implementation of controls;

(f) conduct an annual performance evaluation of the program to determine its effectiveness, with the results of the evaluation reported to the committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in the risk of injury to patients, musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorders by employees caused by patient handling, and include recommendations to increase the program's effectiveness;

(g) when developing architectural plans for constructing or remodeling a health care facility or a unit of a health care facility in which patient handling and movement occurs, consider the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date; and

(h) develop a process by which employees may refuse to perform or be involved in patient handling or movement that the employee reasonably believes in good faith will expose a patient or health care facility employee to an unacceptable risk of injury. Such process shall require that the nurse or direct care worker make a good faith effort to ensure patient safety and bring the matter to the attention of the facility in a timely manner. A health care facility employee who reasonably and in good faith follows the process developed by the health care facility in accordance with this subdivision shall not be the subject of disciplinary action by the health care facility for the refusal to perform or be involved in the patient handling or movement.

§ 2997-1. Activities. The activities enumerated in section twenty-nine hundred ninety-seven-k of this title shall be undertaken consistent with section twenty-eight hundred five-j of this chapter by a covered health care provider and shall be deemed activities of such program as described in such section and any and all information attributable to such activities shall be subject to provisions of section twenty-eight hundred five-m of this chapter and section sixty-five hundred twenty-seven of the education law.

TITLE 2
QUALITY IMPROVEMENT

Section 2998. Patient safety center.

2998-a. Information.

2998-b. Safety goals.

2998-c. Best practices.

2998-d. Voluntary and collaborative reporting system.

2998-e. Reporting in office based surgery.

2998-f. Reporting of the health risk factors of excessive
alcohol consumption.

2999. Contracting with private entities.

2999-a. Public access.

§ 2998. Patient safety center. 1. There is established within the department a patient safety center, referred to in this article as "the center".

2. The purpose of the center is to maximize patient safety, reduce medical errors, and improve the quality of health care by improving systems of data reporting, collection, analysis and dissemination, and to improve public access to health care information not otherwise restricted.

§ 2998-a. Information. 1. The center shall identify available information that is useful for maximizing patient safety, reducing medical errors, and improving health care quality, including information available from federal, state and local agencies. The center shall evaluate reporting requirements and develop recommendations for the legislature to consolidate data collection and eliminate duplicative and unnecessary reporting requirements, and to supplement existing reporting requirements in order to satisfy the requirements of this article.

2. The center shall promote the coordination of the activities of the

center with the duties and responsibilities of the department under title one of this article, and with federal and other programs for improving patient safety or health care quality including programs of the national forum for health care quality measurement and reporting (quality forum).

§ 2998-b. Safety goals. 1. The center shall:

(a) Promote the development and dissemination of regional and statewide performance information, and efforts by health care organizations, health plans, health care providers and health care professionals to participate in voluntary, cooperative efforts to improve patient safety and health care quality, consistent with state law;

(b) Utilize the information collected pursuant to this title to recommend statewide medical safety goals and track the progress of health care providers in meeting these safety goals;

(c) Develop programs to assure the validity of statewide data reporting systems, including the use of random audit;

(d) Analyze and report on health care performance of health care providers and health care professionals in New York state pursuant to this title; and

§ 2998-c. Best practices. 1. The center shall:

(a) Review and promote research to assist health care providers and health plans in identifying systemic problems in health care leading to medical errors or impairing patient safety or health care quality, identifying appropriate quality improvement strategies and developing and adopting health care best practices;

(b) Serve as a clearing house of information for health care providers concerning quality improvement strategies and best practices; and

§ 2998-d. Voluntary and collaborative reporting system. The center, in collaboration with health care providers, shall develop a voluntary and collaborative reporting system, for the purposes of obtaining

information useful for maximizing patient safety, reducing medical errors, and improving the quality of health care pursuant to this title.

§ 2998-e. Reporting in office based surgery. 1. The commissioner may enter into agreements with accrediting agencies to require all office-based surgical practices to conduct quality improvement and quality assurance activities and utilize certification by an appropriate certifying organization, hospital privileging or other equivalent methods to determine competency of practitioners to perform office-based surgery, carry out surveys or complaint/incident investigations and shall report, at a minimum, findings of surveys and complaint/incident investigations, and data for all office-based surgical practices accredited by the accrediting agencies to the department. The department may disclose reports of aggregate data to the public.

2. The information required to be collected, maintained and reported directly to the department and the accrediting agencies and maintained by office-based surgery practices under adverse event reporting, quality improvement and quality assurance activities pursuant to section two hundred thirty-d of this chapter shall be kept confidential and shall not be released, except to the department and except as required or permitted under subdivision nine-a and subparagraph (v) of paragraph (a) of subdivision ten of section two hundred thirty of this chapter. Notwithstanding any other provision of law, none of the information collected, maintained and reported to the department or the accrediting agencies, and maintained by the office-based surgery practices under adverse event reporting, quality improvement and quality assurance activities pursuant to this section shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules.

3. The commissioner shall make, adopt, promulgate and enforce such rules and regulations, as he or she may deem appropriate, to effectuate the purposes of this section. Where any rule or regulation under this section would affect the scope of practice of a health care practitioner licensed, registered or certified under title eight of the education law

other than those licensed under articles one hundred thirty-one or one hundred thirty-one-B of the education law, the rule or regulation shall be made with the concurrence of the commissioner of education.

§ 2998-f. Reporting of the health risk factors of excessive alcohol consumption. The department, in collaboration with the office of addiction services and supports and health care providers, shall collect data on and report the health risk factor of excessive alcohol consumption and alcohol poisoning, including the risk factors of heavy and binge drinking. The report shall be submitted annually, on or before November first, to the governor, the temporary president of senate, the speaker of the assembly and the chairpersons of the assembly and senate health committees. The report shall include, at a minimum, the following information on a county basis:

(a) information on excessive alcohol consumption and alcohol poisoning deaths, including age, gender, ethnicity, and geographic location;

(b) data on emergency room utilization for the treatment of alcohol poisoning; and

(c) any other information necessary to ascertain areas of the state which are experiencing particularly high rates of excessive alcohol consumption and alcohol poisoning, ways to determine if services, resources, and responses in particular areas of the state area having a positive impact on reducing excessive alcohol consumption and alcohol poisoning. Such reporting may be through a web-based dashboard.

§ 2999. Contracting with private entities. The center may contract with one or more private entities to undertake the duties delineated in this title. Such entities shall remain subject to existing confidentiality protections.

§ 2999-a. Public access. Nothing in this title shall abridge public access to information currently available or permitted by any other provision or rule of law. Nothing in this title shall authorize the disclosure of otherwise confidential information, except pursuant to the

express terms of this title.

*** TITLE 3 -- PAY FOR PERFORMANCE**

Section 2999-b. Legislative intent.

2999-c. Definition.

2999-d. Commissioner's workgroup.

2999-e. Demonstration projects.

2999-f. Authorizations.

* NB Expired April 1, 2011

*** § 2999-b. Legislative intent.** It is the intent of the legislature to promote patient safety and the quality of care, as well as the cost effectiveness of such care, by convening providers and payers to develop clinical measures, and the metrics on which to measure provider performance. Thereafter, it is the legislature's intent to encourage and support regional demonstration projects involving multiple payors utilizing such metrics as the basis for providing financial incentives to providers to achieve increased quality and cost effectiveness.

* NB Expired April 1, 2011

*** § 2999-c. Definition.** "Health care plan" shall have the same meaning set forth in subdivision four-e of section forty-nine hundred of this chapter.

* NB Expired April 1, 2011

*** § 2999-d. Commissioner's workgroup.** 1. The commissioner shall, within ninety days of the effective date of this title, convene and chair, directly or through a designee or designees, a workgroup including but not necessarily limited to representatives of statewide and regional health care provider associations, health care plan associations and conferences, hospital representatives, consumers, labor and self-insured employers. The commissioner shall consider recommendations and criteria developed by the workgroup in making

determinations under this title.

2. The workgroup shall seek consensus on clinical measures and measurement criteria necessary and appropriate to achieve improvement in quality performance by providers in delivering health care services; further, it shall develop metrics to be utilized by demonstration projects selected pursuant to the provisions of this title which will, when implemented:

(a) promote the use of best practices through the development of broadly agreed upon evidence-based performance measures;

(b) improve care coordination through the participation of multiple stakeholders;

(c) institute long-term quality improvement;

(d) encourage appropriate utilization of health care services and improve health outcomes through the use of evidence-based medicine practice guidelines; and

(e) promote self-management by consumers through the implementation of patient-specific metrics and resource supports for consumers.

3. In its recommendations, the workgroup shall give consideration to the appropriate number of participants in each demonstration project as well as the geographic boundaries of each demonstration project.

* NB Expired April 1, 2011

*** § 2999-e. Demonstration projects.** 1. Notwithstanding any inconsistent regulation of the department, the commissioner is authorized and shall select up to five demonstration projects throughout the state, pursuant to a competitive bid or request for proposal process, which have been determined by the commissioner to encompass one or more of the following elements:

(a) use of the workgroup metrics to measure and reward physician, clinic and hospital performance;

(b) involvement of multiple payers, including government programs, multiple providers and multiple communities voluntarily agreeing to employ the workgroup metrics to reward physician, clinic and hospital performance for quality improvement;

(c) use of information technology to share patient information among providers to improve coordination of patient care;

(d) targeted improvement in care coordination through the participation of multiple stakeholders;

(e) collection, analysis and public reporting on the risk-adjusted measures, incentives and processes utilized, and outcomes; and

(f) programs to enhance patient self-management through adherence to treatment plans.

2. In evaluating proposed demonstration projects, the commissioner shall consider the degree to which a proposed project reflects the elements listed above including demonstrated commitments on the part of all practitioners, providers and payors to participate.

3. (a) There shall be no more than five demonstration projects under this title.

(b) Where any demonstration project involves recipients of Medicaid, family health plus, or child health plus, those recipients shall not constitute more than half the individuals covered by the demonstration project and their health care, measured in the amount of annual reimbursement, shall not cover more than half of the health care covered by the demonstration project.

(c) No demonstration project shall limit the scope or terms of coverage or limit the grounds or procedural rights for appealing a denial of reimbursement for a health care service, for any consumer, enrollee, or recipient subject to the demonstration project.

* NB Expired April 1, 2011

*** § 2999-f. Authorizations.** 1. The commissioner may contract with projects and provide grants to support projects to the extent funds are appropriated for such purpose.

2. Upon the request of a sponsoring health plan, the commissioner may authorize the participation of the Medicaid, family health plus and child health plus programs in one or more demonstration projects, provided that enrollee participation shall be on a voluntary basis.

3. The commissioner may contract with entities possessing expertise deemed necessary to assist in the evaluation of the metrics developed by the workgroup and individual project designs to the extent funds are appropriated for such purpose.

4. The commissioner shall report to the governor and the legislature on or before March first, two thousand six, on the results of the commissioner's workgroup, and shall report within three years of the effective date of this title, and again six months prior to the expiration date of this title, on the number of demonstration projects chosen and on the operation and effectiveness of each demonstration undertaken, together with any recommendations the commissioner deems appropriate.

5. Nothing in this title shall:

(a) diminish or waive any right, remedy or benefit of any health care provider, consumer, enrollee, or recipient under the provisions of this chapter, the insurance law or the social services law; or

(b) diminish, waive, or provide any exemption from any provision of the anti-trust or trade regulation laws of the state or the United States; or

(c) diminish, waive or supersede any provision of an applicable collective bargaining agreement.

6. This title shall expire on April first, two thousand eleven.

* NB Expired April 1, 2011

TITLE 4

NEW YORK STATE MEDICAL INDEMNITY FUND

Section 2999-g. Purpose of this title.

2999-h. Definitions.

2999-i. Custody and administration of the fund.

2999-j. Payments from the fund.

§ 2999-g. Purpose of this title. Creation of the New York state medical indemnity fund. There is hereby created the New York state medical indemnity fund (the "fund"). The purpose of the fund is to provide a funding source for future health care costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage.

§ 2999-h. Definitions. As used in this title, unless the context or subject matter requires otherwise:

1. "Birth-related neurological injury" means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation, or by other medical services provided or not provided during delivery admission, that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only.

2. "Fund" means the New York state medical indemnity fund.

3. "Qualifying health care costs" means the future medical, hospital, surgical, nursing, dental, rehabilitation, habilitation, respite, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications, transportation for purposes of health care related appointments, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are necessary to meet their health care needs, as determined by their treating physicians, physician assistants, or nurse practitioners and as otherwise defined by the commissioner in regulation.

4. "Qualified plaintiff" means every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged

medical malpractice, and has settled his or her lawsuit or claim therefor; and (iii) has been ordered to be enrolled in the fund by a court in New York state.

§ 2999-i. Custody and administration of the fund. 1. (a) The commissioner of taxation and finance shall be the custodian of the fund and the special account established pursuant to section ninety-nine-t of the state finance law. All payments from the fund shall be made by the commissioner of taxation and finance upon certificates signed by the commissioner, or his or her designee, as hereinafter provided. The fund shall be separate and apart from any other fund and from all other state monies; provided, however, that monies of the fund may be invested as set forth in paragraph (b) of this subdivision. No monies from the fund shall be transferred to any other fund, nor shall any such monies be applied to the making of any payment for any purpose other than the purpose set forth in this title.

(b) Any monies of the fund not required for immediate use may, at the discretion of the commissioner in consultation with the director of the budget, be invested by the commissioner of taxation and finance in obligations of the United States or the state or obligations the principal and interest of which are guaranteed by the United States or the state. The proceeds of any such investment shall be retained by the fund as assets to be used for the purposes of the fund.

2. (a) The fund shall be administered by the commissioner or his or her designee in accordance with the provisions of this article.

(b) The commissioner shall have all powers necessary and proper to carry out the purposes of the fund.

(c) Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law or any other contrary provision of law, the superintendent of financial services is authorized to assign and the commissioner is authorized to receive assignment of any and all contracts entered into by the superintendent of financial services to administer the fund for periods prior to October first, two thousand nineteen.

(d) The department shall post on its website information about the

fund and the process for enrollment in the fund.

3. The expense of administering the fund shall be paid from the fund.

4. Monies for the fund will be provided pursuant to this chapter.

5. For the state fiscal year beginning April first, two thousand eleven and ending March thirty-first, two thousand twelve, the state fiscal year beginning April first, two thousand twelve and ending March thirty-first, two thousand thirteen, and the state fiscal year beginning April first, two thousand thirteen and ending March thirty-first, two thousand fourteen, the superintendent of financial services shall cause to be deposited into the fund for each such fiscal year the amount appropriated for such purpose. Beginning April first, two thousand fourteen and annually thereafter, the superintendent of financial services or the commissioner, whoever is administering the fund for the applicable period shall cause to be deposited into the fund, subject to available appropriations, an amount equal to the difference between the amount appropriated to the fund in the preceding fiscal year, as increased by the adjustment factor defined in subdivision seven of this section, and the assets of the fund at the conclusion of that fiscal year.

6. (a) Following the deposit referenced in subdivision five of this section, the commissioner shall conduct an actuarial calculation of the estimated liabilities of the fund for the coming year resulting from the qualified plaintiffs enrolled in the fund. The administrator shall from time to time adjust such calculation in accordance with subdivision seven of this section. If the total of all estimates of current liabilities equals or exceeds eighty percent of the fund's assets, then the fund shall not accept any new enrollments until a new deposit has been made pursuant to subdivision five of this section. When, as a result of such new deposit, the fund's liabilities no longer exceed eighty percent of the fund's assets, the fund administrator shall enroll new qualified plaintiffs in the order that an application for enrollment has been submitted in accordance with subdivision seven of section twenty-nine hundred ninety-nine-j of this title.

(b) Whenever enrollment is suspended pursuant to paragraph (a) of this subdivision and until such time as enrollment resumes pursuant to such paragraph: (i) notice of such suspension shall be promptly posted on the department's website; (ii) the fund administrator shall deny each application for enrollment that had been received but not accepted prior to the date of suspension and each application for enrollment received after the date of such suspension; and (iii) notification of each such denial shall be made to the plaintiff or claimant or persons authorized to act on behalf of such plaintiff or claimant and all defendants in regard to such plaintiff or claimant, to the extent they are known to the fund administrator. Judgments and settlements for plaintiffs or claimants for whom applications are denied under this paragraph or who are not eligible for enrollment due to suspension pursuant to paragraph (a) of this subdivision shall be satisfied as if this title had not been enacted.

(c) Following a suspension, whenever enrollment resumes pursuant to paragraph (a) of this subdivision, notice that enrollment has resumed shall be promptly posted on the department's website.

(d) The suspension of enrollment pursuant to paragraph (a) of this subdivision shall not impact payment under the fund for any qualified plaintiffs already enrolled in the fund.

7. For purposes of this section, the adjustment factor referenced in this section shall be the ten year rolling average medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years.

§ 2999-j. Payments from the fund. 1. The fund shall be used to pay the qualifying health care costs of qualified plaintiffs.

2. The provision of qualifying health care costs to qualified plaintiffs shall not be subject to prior authorization, except as described by the commissioner in regulation; provided, however:

(a) such regulation shall not prevent qualified plaintiffs from receiving care or assistance that would, at a minimum, be authorized under the medicaid program;

(b) if any prior authorization is required by such regulation, the regulation shall require that requests for prior authorization be processed within a reasonably prompt period of time and shall identify a process for prompt administrative review of any denial of a request for prior authorization; and

(c) such regulations shall not prohibit qualifying health care costs on the grounds that the qualifying health care cost may incidentally benefit other members of the household, provided that whether the qualifying health care cost primarily benefits the patient may be considered.

3. In determining the amount of qualifying health care costs to be paid from the fund, any such cost or expense that was or will, with reasonable certainty, be paid, replaced or indemnified from any collateral source as provided by subdivision (a) of section forty-five hundred forty-five of the civil practice law and rules shall not constitute a qualifying health care cost and shall not be paid from the fund. For purposes of this title, "collateral source" shall not include medicare or Medicaid.

* 4. The amount of qualifying health care costs to be paid from the fund shall be calculated on the basis of one hundred percent of the usual and customary cost. For the purposes of this section, "usual and customary costs" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of financial services. If no such rates are available qualifying health care costs shall be calculated on the basis of no less than one hundred thirty percent of Medicaid or Medicare rates of reimbursement, whichever is higher. If no such rate exists, costs shall be reimbursed as defined by the commissioner in regulation.

* NB Effective until June 1, 2027

* 4. The amount of qualifying health care costs to be paid from the fund shall be calculated: (a) with respect to services provided in private physician practices on the basis of one hundred percent of the usual and customary rates, as defined by the commissioner in regulation;

or (b) with respect to all other services, on the basis of Medicaid rates of reimbursement or, where no such rates are available, as defined by the commissioner in regulation.

* NB Effective June 1, 2027

5. Claims for the payment or reimbursement from the fund of qualifying health care costs shall be made upon forms prescribed and furnished by the fund administrator in conjunction with regulations establishing a mechanism for submission of claims by health care providers directly to the fund, where practicable.

6. (a) Every settlement agreement for claims arising out of a plaintiff's or claimant's birth related neurological injury subject to this title, and that provides for the payment of future medical expenses for the plaintiff or claimant, shall provide that all payments for future medical expenses shall be paid in accordance with this title in lieu of that portion of the settlement agreement that provides for payment of such expenses. The plaintiff's or claimant's future medical expenses shall be paid in accordance with this title. When such a settlement agreement does not so provide, the court shall direct the modification of the agreement to include such term as a condition of court approval.

(b) In any case where the jury or court has made an award for future medical expenses arising out of a birth related neurological injury, any party to such action or person authorized to act on behalf of such party may make application to the court that the judgment reflect that, in lieu of that portion of the award that provides for payment of such expenses, the future medical expenses of the plaintiff shall be paid out of the fund in accordance with this title. Upon a finding by the court that the applicant has made a prima facie showing that the plaintiff is a qualified plaintiff, the court shall ensure that the judgment so provides.

7. A qualified plaintiff shall be enrolled when (a) such plaintiff or person authorized to act on behalf of such person, upon notice to all defendants, or any of the defendants in regard to the plaintiff's claim, upon notice to such plaintiff, makes an application for enrollment by

providing the fund administrator with a certified copy of the judgment or of the court approved settlement agreement; and (b) the fund administrator determines that the relevant provisions of subdivision six of this section have been met; provided that no enrollment shall occur when the fund is closed to enrollment pursuant to subdivision six of section twenty-nine hundred ninety-nine-i of this title.

8. As to all claims, the fund administrator shall:

(a) determine which of such costs are qualifying health care costs to be paid from the fund; and

(b) thereupon certify to the commissioner of taxation and finance those costs that have been determined to be qualifying health care costs to be paid from the fund.

9. Payments from the fund shall be made by the commissioner of taxation and finance on the said certificate of the commissioner. No payment shall be made by the commissioner of taxation and finance in excess of the amount certified. Promptly upon receipt of the said certificate of the commissioner, the commissioner of taxation and finance shall pay the qualified plaintiff's health care provider or reimburse the qualified plaintiff the amount so certified for payment.

10. Payment from the fund shall not give the fund any right of recovery against any qualified plaintiff or such qualified plaintiff's attorney except in the case of fraud or mistake.

11. All health care providers shall accept from qualified plaintiff's or persons authorized to act on behalf of such plaintiff's assignments of the right to receive payments from the fund for qualifying health care costs. Such payments shall constitute payment in full for any services provided to a qualified plaintiff in accordance with this article.

12. Health insurers (other than medicare and Medicaid) shall be the primary payers of qualifying health care costs of qualified plaintiffs. Such costs shall be paid from the fund only to the extent that health insurers or other collateral sources or other persons are not otherwise

obligated to make payments therefor. Health insurers that make payments for qualifying health care costs to or on behalf of qualified plaintiffs shall have no right of recovery against and shall have no lien upon the fund or any person or entity nor shall the fund constitute an additional payment source to offset the payments otherwise contractually required to be made by such health insurers. The superintendent of financial services shall have the authority to enforce the provisions of this subdivision upon the referral of the commissioner.

13. Except as provided for by this title, with respect to a qualified plaintiff, no payment shall be required to be made by any defendant or such defendant's insurer for qualifying health care costs and no judgment shall be made or entered requiring that any such payment be made by any defendant or such defendant's insurer for such health care costs.

14. The determination of the qualified plaintiff's attorney's fee shall be based upon the entire sum awarded by the jury or the court or the full sum of the settlement, as the case may be. The qualified plaintiff's attorney's fee shall be paid in a lump sum by the defendants and their insurers pursuant to section four hundred seventy-four-a of the judiciary law; provided however that the portion of the attorney fee that is allocated to the non-fund elements of damages shall be deducted from the non-fund portion of the award in a proportional manner.

15. The commissioner shall promulgate, amend and enforce all rules and regulations necessary for the proper administration of the fund in accordance with the provisions of this section, including, but not limited to, those concerning the payment of claims and concerning the actuarial calculations necessary to determine, annually, the total amount to be paid into the fund as provided herein, and as otherwise needed to implement this title.

TITLE 5

NEW YORK STATE HOSPITAL QUALITY INITIATIVE

Section 2999-m. New York state hospital quality initiative.

§ 2999-m. New York state hospital quality initiative. The New York state hospital quality initiative, including the New York state obstetrical patient safety workgroup, will be created in the department of health to be comprised of medical, hospital and academic experts and other stakeholders chosen by the commissioner.

The New York state quality initiative will oversee the general dissemination of initiatives, guidance, and best practices to general hospitals. Activities will include but not be limited to: building cultures of patient safety and implementing evidence based care in target areas. The workgroup will undertake collaborative work to improve obstetrical care outcomes and quality of care, based on identifying and implementing evidence based practices, and clinical protocols that can be standardized and adopted by hospitals including but not limited to:

(a) Surveying, reviewing and analyzing current "best" practices employed in obstetrical cases, including exploring the use of "virtual grand rounds";

(b) Undertaking a review of claims in an effort to develop a set of "standard best practices" for deliveries in New York state;

(c) Formulating and recommending to the commissioner best practice standards and designing new programs for implementation and improved outcomes, including but not limited to, clinical bundles for high priority conditions, electronic fetal monitoring training and certification, and team training; and

(d) Engaging the existing regional perinatal center network in dialogues regarding the above topics and making recommendations to improve and/or upgrade assistance and communication to smaller hospitals.

ARTICLE 29-E

ACCOUNTABLE CARE ORGANIZATIONS

Section 2999-n. Accountable care organizations; findings; purpose.

2999-o. Definitions.

2999-p. Establishment of ACOs.

2999-q. Accountable care organizations; requirements.

2999-r. Other laws.

§ 2999-n. Accountable care organizations; findings; purpose. The legislature finds that the formation and operation of accountable care organizations under this article, and subject to appropriate regulation, can be consistent with the purposes of federal and state anti-trust, anti-referral, and other statutes, including reducing over-utilization and expenditures. The legislature finds that the development of accountable care organizations under this article will reduce health care costs, promote effective allocation of health care resources, and enhance the quality and accessibility of health care. The legislature finds that this article is necessary to promote the formation of accountable care organizations and protect the public interest and the interests of patients and health care providers.

§ 2999-o. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Accountable care organization" or "ACO" means an organization of clinically integrated health care providers certified by the commissioner under this article.

2. "ACO participant" or "participant" means a health care provider that is one of the health care providers that comprise the ACO.

3. "Certificate of authority" or "certificate" means a certificate of authority issued by the commissioner under this article.

4. "CMS" means the federal centers for Medicare and Medicaid services.

5. "CMS regulations" means applicable federal laws and CMS regulations and policies.

6. "Health care provider" includes but is not limited to an entity licensed or certified under article twenty-eight or thirty-six of this chapter; an entity licensed or certified under article sixteen, thirty-one or thirty-two of the mental hygiene law; or a health care practitioner licensed or certified under title eight of the education law or a lawful combination of such health care practitioners; and may also include, to the extent provided by regulation of the commissioner, other entities that provide technical assistance, information systems and services, care coordination and other services to health care providers and patients participating in an ACO.

7. "Medicare-only ACO" means an ACO issued a certificate of authority under subdivision four of section twenty-nine hundred ninety-nine-p of this article.

8. "Primary care" means the health care fields of family practice, general pediatrics, primary care internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification, provided by a health care provider acting within his, her, or its lawful scope of practice.

9. "Third-party health care payer" has its ordinary meanings and may include any entities provided for by regulation of the commissioner, which may include an entity such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

§ 2999-p. Establishment of ACOs. 1. An accountable care organization: (a) is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO's patients; in accordance with this article; and (b) has been issued a certificate of authority by the commissioner under this article.

2. The commissioner shall establish a program within the department to promote and regulate the use of ACOs to deliver an array of health care services for the purpose of improving the quality, coordination and accountability of services provided to patients in New York.

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

4. (a) Notwithstanding subdivision three of this section, the commissioner shall issue a certificate of authority as a Medicare-only ACO to an entity authorized by CMS to be an accountable care organization under the Medicare program, upon receiving an application to be a Medicare-only ACO from the entity documenting its status under this subdivision. A certificate of authority under this subdivision shall only apply to the Medicare-only ACO's actions in relation to Medicare beneficiaries under its authorization from CMS.

(b) To the extent consistent with CMS regulations, a Medicare-only ACO shall be subject to:

(i) subdivision seven of section twenty-nine hundred ninety-nine-q and subdivisions one, two and three of section twenty-nine hundred ninety-nine-r of this article, without regard to whether the commissioner has made regulations under this article; and

(ii) other provisions of this article to the extent specifically provided by the commissioner in regulations consistent with this article.

5. The commissioner may limit, suspend, or terminate a certificate of authority if an ACO is not operating in accordance with this article.

6. The commissioner is authorized to seek federal approvals and waivers to implement this article, including but not limited to those approvals or waivers necessary to obtain federal financial

participation.

§ 2999-q. Accountable care organizations; requirements. 1. The commissioner shall make regulations establishing criteria for certificates of authority, quality standards for ACOs, reporting requirements and other matters deemed to be appropriate and necessary in the operation and evaluation of ACOs under this article. In making such regulations, the commissioner shall consult with the superintendent of financial services, health care providers, third-party health care payers, advocates representing patients, and other appropriate parties. Such regulations shall be consistent, to the extent practical and consistent with this article, with CMS regulations for accountable care organizations under the Medicare program.

2. Such regulations may, and shall as necessary for purposes of this article, address matters including but not limited to:

(a) The governance, leadership and management structure of the ACO that reasonably and equitably represents the ACO's participants and the ACO's patients, including the manner in which clinical and administrative systems and clinical participation will be managed;

(b) Definition of the population proposed to be served by the ACO, which may include reference to a geographical area and patient characteristics;

(c) The character, competence and fiscal responsibility and soundness of an ACO and its principals, if and to the extent deemed appropriate by the commissioner;

(d) The adequacy of an ACO's network of participating health care providers, including primary care health care providers;

(e) Mechanisms by which an ACO will provide, manage, and coordinate quality health care for its patients including where practicable elevating the services of primary care health care providers to meet patient-centered medical home standards, coordinating services for complex high-need patients, and providing access to health care providers that are not participants in the ACO;

(f) Mechanisms by which the ACO shall receive and distribute payments to its participating health care providers, which may include incentive

payments (which may include medical home payments) or mechanisms for pooling payments received by participating health care providers from third-party payers and patients;

(g) Mechanisms and criteria for accepting health care providers to participate in the ACO that are related to the needs of the patient population to be served and needs and purposes of the ACO, and preventing unreasonable discrimination;

(h) Mechanisms for quality assurance and grievance procedures for patients or health care providers where appropriate, and procedures for reviewing and appealing patient care decisions;

(i) Mechanisms that promote evidence-based health care, patient engagement, coordination of care, electronic health records, including participation in health information exchanges, other enabling technologies and integrated, efficient and effective health care services;

(j) Performance standards for, and measures to assess, the quality and utilization of care provided by an ACO;

(k) Appropriate requirements for ACOs to promote compliance with the purposes of this article;

(l) Posting on the department's website information about ACOs that would be useful to health care providers and patients, including similar metrics as the commissioner publishes for other organizations such as Medicaid managed care providers under section three hundred sixty-four-j of the social services law and health homes under section three hundred sixty-five-l of the social services law;

(m) Requirements for the submission of information and data by ACOs and their participating and affiliated health care providers as necessary for the evaluation of the success of ACOs;

(n) Protection of patient rights as appropriate;

(o) The impact of the establishment and operation of an ACO, including providing that it shall not diminish access to any health care service for the population served and in the area served; and

(p) Establishment of standards, as appropriate, to promote the ability of an ACO to participate in applicable federal programs for ACOs.

3. (a) The ACO shall provide for meaningful participation in the composition and control of the ACO's governing body for ACO participants

or their designated representatives.

(b) The ACO governing body shall include at least one representative of each of the following groups: (i) recipients of Medicaid, family health plus, or child health plus; (ii) persons with other health coverage; and (iii) persons who do not have health coverage. Such representatives shall have no conflict of interest with the ACO and no immediate family member with a conflict of interest with the ACO.

(c) At least seventy-five percent control of the ACO's governing body shall be held by ACO participants.

(d) Members of the ACO governing body shall have a fiduciary relationship with the ACO and shall be subject to conflict of interest requirements adopted by the ACO and in regulations of the commissioner.

(e) The ACO's finances, including dividends and other return on capital, debt structure, executive compensation, and ACO participant compensation, shall be arranged and conducted to maximize the achievement of the purposes of this article.

4. (a) An ACO shall use its best efforts to include among its participants, on reasonable terms and conditions, any federally-qualified health center that is willing to be a participant and that serves the area and population served by the ACO.

(b) An ACO may seek to focus on providing health care services to patients with one or more chronic conditions or special needs. However, an ACO may not otherwise, on the basis of a person's medical or demographic characteristics, discriminate for or against or discourage or encourage any person or person with respect to enrolling or participating in the ACO.

(c) An ACO shall not, by incentives or otherwise, discourage a health care provider from providing or an enrollee or patient from seeking appropriate health care services.

(d) An ACO shall not discriminate against or disadvantage a patient or patient's representative for the exercise of patient autonomy.

(e) An ACO may not limit or restrict beneficiaries to use of providers contracted or affiliated with the ACO. An ACO may not require a patient to obtain the prior approval, from a primary care gatekeeper or otherwise, before utilizing the services of other providers. An ACO may not make adverse determinations as defined in article forty-nine of this

chapter.

5. An ACO may provide care coordination for its participating patients, which (a) shall include but not be limited to managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy; and (b) is not a requirement for prior authorization for health care services, and referral shall not be required for a member to receive a health care service.

6. (a) Subject to regulations of the commissioner: (i) an ACO may enter into arrangements with one or more third-party health care payers to establish payment methodologies for health care services for the third-party health care payer's enrollees provided by the ACO or for which the ACO is responsible, such as full or partial capitation or other arrangements; (ii) such arrangements may include provision for the ACO to receive and distribute payments to the ACO's participating health care providers, including incentive payments and payments for health care services from third-party health care payers and patients; and (iii) an ACO may include mechanisms for pooling payments received by participating health care providers from third-party payers and patients.

(b) Subject to regulations of the commissioner, the commissioner, in consultation with the superintendent of financial services, may authorize a third-party health care payer to participate in payment methodologies with an ACO under this subdivision, notwithstanding any contrary provision of this chapter, the insurance law, the social services law, or the elder law, on finding that the payment methodology is consistent with the purposes of this article.

(c) An ACO may contract with a third-party health care payer to serve as all or part of the third-party health care payer's provider network or care coordination agent, provided in that case the ACO shall be subject to all provisions of this chapter or the insurance law which are applicable to the provider network of the third-party health care payer.

7. The provision of health care services directly or indirectly by an ACO through health care providers shall not be considered the practice of a profession under title eight of the education law by the ACO.

§ 2999-r. Other laws. 1. (a) It is the policy of the state to permit and encourage cooperative, collaborative and integrative arrangements among third-party health care payers and health care providers who might otherwise be competitors under the active supervision of the commissioner. To the extent that it is necessary to accomplish the purposes of this article, competition may be supplanted and the state may provide state action immunity under state and federal antitrust laws to payors and health care providers.

(b) The commissioner shall engage in state supervision to promote state action immunity under state and federal antitrust laws and may inspect, require, or request additional documentation and take other actions under this article to verify and make sure that this article is implemented in accordance with its intent and purpose.

2. With respect to the planning, implementation, and operation of ACOs, the commissioner, by regulation, shall specifically delineate safe harbors that exempt ACOs from the application of the following statutes:

(a) article twenty-two of the general business law relating to arrangements and agreements in restraint of trade;

(b) article one hundred thirty-one-A of the education law relating to fee-splitting arrangements; and

(c) title two-D of article two of this chapter relating to health care practitioner referrals.

3. For the purposes of this article, an ACO shall be deemed to be a hospital for purposes of sections twenty-eight hundred five-j, twenty-eight hundred five-k, twenty-eight hundred five-l and twenty-eight hundred five-m of this chapter and subdivisions three and five of section sixty-five hundred twenty-seven of the education law.

4. The commissioner is authorized to seek federal grants, approvals, and waivers to implement this article, including federal financial

participation under public health coverage. The commissioner shall provide copies of applications and other documents, including drafts, submitted to the federal government seeking such federal grants, approvals, and waivers to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees simultaneously with their submission to the federal government.

5. The commissioner may directly, or by contract with not-for-profit organizations, provide:

(a) consumer assistance to patients served by an ACO as to matters relating to ACOs;

(b) technical and other assistance to health care providers participating in an ACO as to matters relating to the ACO;

(c) assistance to ACOs to promote their formation and improve their operation, including assistance under section twenty-eight hundred eighteen of this chapter; and

(d) information sharing and other assistance among ACOs to improve the operation of ACOs.

ARTICLE 29-EE

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Section 2999-s. Definitions.

2999-t. Program established.

2999-u. Licensure.

2999-v. Eligibility and enrollment.

2999-w. Benefits.

2999-x. Reimbursement.

2999-y. Regulations and applicable laws.

§ 2999-s. Definitions. For purposes of this article, the following definitions apply:

1. "PACE organization" means an entity as defined in 42 U.S.C. § 1395(eee) and established in accordance with federal public law 105-33,

subtitle I of title IV of the Balanced Budget Act of 1997, and licensed or otherwise authorized to operate under this article.

2. "Program of all-inclusive care of the elderly" or "PACE" is a federally recognized model of comprehensive care for persons fifty-five years of age or older eligible for Medicaid and may also be eligible for Medicare, qualifying for nursing home levels of care who wish to remain in their community (see, Sections 1894 and 1934 to Title XVIII of the Social Security Act; 42 CFR 460), and established under this article.

3. "Medicaid" means title eleven of article five of the social services law and the program thereunder. "Medicare" means title XVIII of the federal social security act and the programs thereunder.

4. "CMS" means the federal Centers for Medicare and Medicaid Services.

5. "Enrollee" means an individual enrolled in a PACE organization.

§ 2999-t. Program established. 1. The program of all-inclusive care of the elderly is established in the department to provide community-based, risk-based, and capitated long-term care services as optional services under Medicaid and, where applicable, under Medicare, as well as under contracts among CMS, the department and PACE organizations.

2. A PACE organization operating at the time this article becomes law may continue to operate while the organization transitions into full compliance with this article, under a process and requirements established by the commissioner.

§ 2999-u. Licensure. 1. The commissioner shall license an entity applying for licensure as a PACE organization if the applicant demonstrates to the satisfaction of the commissioner that the applicant will:

(a) comply with the requirements of a PACE organization under applicable federal law and regulations;

(b) provide a facility or facilities at which primary care and other services are furnished to enrollees;

(c) provide an interdisciplinary team approach to care management, care delivery and care planning;

(d) comply with this article, the applicable provisions of articles twenty-eight, thirty-six and forty-four of this chapter and regulations thereunder, and regulations of the commissioner under this article; and

(e) enter into a PACE organization contract and agreement with the department and CMS.

2. (a) A PACE organization shall serve an approved geographic service area.

(b) A PACE organization and its incorporators, directors, sponsors, stockholders, members, and operators shall have the experience, competence, and standing in the community as to give reasonable assurance of their ability to operate the organization to provide a consistently high level of care for enrollees and comply with this article. A PACE organization shall demonstrate that where any incorporator, director, sponsor, stockholder, member, or operator of the organization holds, or within the past seven years has held, a controlling interest or been a controlling person in an organization or facility licensed under this chapter, a consistently high level of care has been rendered in each such organization or facility.

(c) A PACE organization shall meet requirements for financial solvency under paragraph (c) of subdivision one of section forty-four hundred three of this chapter, including a contingent reserve requirement which may, by regulations of the commissioner, be different from that required by that paragraph.

(d) A PACE organization shall be deemed to be a health maintenance organization under article forty-four of this chapter for purposes of subdivision one of section sixty-five hundred twenty-seven of the education law.

3. (a) The commissioner shall establish in regulation a unified licensure process for PACE organizations that includes the applicable program requirements of this article and articles twenty-eight, thirty-six and forty-four of this chapter.

(b) A license under this article shall require approval of the public health and health planning council.

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

- (a) (i) be at least fifty-five years old;
 - (ii) meet the eligibility requirements for a nursing home level of care;
 - (iii) reside within the PACE organization's approved service area;
 - (iv) be able to be maintained safely in the community-based setting with the assistance of the PACE organization; and
 - (v) meet any additional program specific eligibility conditions imposed under the PACE program agreement between the PACE organization, the department, and CMS; or
- (b) be otherwise eligible to participate in a PACE demonstration or specialty program authorized by the federal PACE Innovation Act and approved by the department and CMS.

2. Enrollment in a PACE organization shall be voluntary for the eligible individual.

§ 2999-w. Benefits. 1. A PACE organization shall provide the following benefits to its enrollees:

- (a) all benefits under Medicaid, including under section three hundred sixty-four-j of the social services law;
- (b) all benefits under Medicare, for enrollees that are enrolled in Medicare; and
- (c) other services determined necessary by the PACE organization's interdisciplinary team to improve and maintain the enrollee's overall health status.

2. A PACE organization may provide fiscal intermediary services if approved under section three hundred sixty-five-f of the social services law.

§ 2999-x. Reimbursement. 1. The commissioner shall develop and implement, consistent with applicable federal requirements, reimbursement rates and methodologies for Medicaid services provided by a PACE organization to its enrollees.

2. The commissioner shall provide, or shall require any independent actuary used to review PACE reimbursement rates to provide, to PACE organizations the documents and information consistent with the requirements under paragraph (c) of subdivision eighteen of section three hundred sixty-four-j of the social services law.

§ 2999-y. Regulations and applicable laws. 1. The commissioner shall make regulations and take other actions reasonably necessary to implement this article, including the establishment of any rules and processes appropriate for the safe, efficient and orderly administration of the program and for the maintenance and revocation of licensure under this article.

2. (a) Licensure granted under this article may, in accordance with the approval by the commissioner, entitle the PACE organization to act in the capacity and perform the activities of a diagnostic and treatment center, home care services agency, health maintenance organization, or managed long term care plan for which licensure or certification is otherwise required under article twenty-eight, thirty-six, or forty-four of this chapter as applicable without such separate license or certification for purposes relating to the PACE.

(b) To the extent that a PACE organization is acting in the capacity or performing an activity for which licensure or certification is otherwise required under article twenty-eight, thirty-six, or forty-four of this chapter, the PACE organization shall comply with the applicable requirements of such articles and any applicable regulations adopted thereunder; except that where such requirements are inconsistent with the requirements of this article or regulations adopted by the commissioner under this article, the requirements of this article and such regulations shall apply.

3. The commissioner may apply for federal waivers under Medicaid or demonstration programs under Medicare relating to the PACE program, provided that the waiver or demonstration shall not diminish any right or benefit of enrollees under this article.

ARTICLE 29-F

IMPROVED INTEGRATION OF HEALTH CARE AND FINANCING

Section 2999-aa. Antitrust provisions, state oversight.

2999-bb. Department authority.

§ 2999-aa. Antitrust provisions, state oversight. 1. In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements, or the planning and negotiations that precede them, might be anti-competitive within the meaning and intent of the state and federal antitrust laws, the intent of the state is to supplant competition with such arrangements under the active supervision and related administrative actions of the commissioner as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others pursuant to this article, where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition. The commissioner shall not approve an arrangement for which state action immunity is sought under this article without first consulting with, and receiving a recommendation from, the public health and health planning council. No arrangement under this article shall be approved after December thirty-first, two thousand twenty-eight.

2. The commissioner or his or her duly authorized representative may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws.

§ 2999-bb. Department authority. The department shall promulgate regulations to implement this article. Such regulations shall provide standards for determining which proposed collaborations, integrations, mergers or acquisitions shall be covered by this article and the manner by which the interests set forth in the legislative findings shall be advanced through regulatory oversight. The department shall further be authorized to impose fees as appropriate to facilitate the implementation of this article. This article is not intended to limit the authority of the attorney general of the state of New York.

ARTICLE 29-G

TELEHEALTH DELIVERY OF SERVICES

Section 2999-cc. Definitions.

2999-dd. Telehealth delivery of services.

2999-ee. Increased application of telehealth.

§ 2999-cc. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Distant site" means a site at which a telehealth provider is located while delivering health care services by means of telehealth. Any site within the United States or United States' territories is eligible to be a distant site for delivery and payment purposes.

2. "Telehealth provider" means:

(a) a physician licensed pursuant to article one hundred thirty-one of the education law;

(b) a physician assistant licensed pursuant to article one hundred thirty-one-B of the education law;

(c) a dentist licensed pursuant to article one hundred thirty-three of the education law;

(d) a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law;

(e) a registered professional nurse licensed pursuant to article one hundred thirty-nine of the education law only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring;

(f) a podiatrist licensed pursuant to article one hundred forty-one of the education law;

(g) an optometrist licensed pursuant to article one hundred forty-three of the education law;

(h) a psychologist licensed pursuant to article one hundred fifty-three of the education law;

(i) a social worker licensed pursuant to article one hundred fifty-four of the education law;

(j) a speech language pathologist or audiologist licensed pursuant to article one hundred fifty-nine of the education law;

(k) a midwife licensed pursuant to article one hundred forty of the education law;

(l) a physical therapist licensed pursuant to article one hundred thirty-six of the education law;

(m) an occupational therapist licensed pursuant to article one hundred fifty-six of the education law;

(n) a person who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal centers for medicare and medicaid services;

(o) a person who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board;

(p) a person who is certified as a genetic counselor by the American Board of Genetic Counseling, or a successor national certification board;

(q) a hospital as defined in article twenty-eight of this chapter, including residential health care facilities serving special needs populations;

(r) a home care services agency as defined in article thirty-six of this chapter;

(s) a hospice as defined in article forty of this chapter;

(t) credentialed alcoholism and substance abuse counselors credentialed by the office of addiction services and supports or by a credentialing entity approved by such office pursuant to section 19.07 of the mental hygiene law;

(u) providers authorized to provide services and service coordination under the early intervention program pursuant to article twenty-five of this chapter;

(v) clinics licensed or certified under article sixteen of the mental hygiene law and certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities;

(w) a care manager employed by or under contract to a health home program, patient centered medical home, office for people with developmental disabilities Care Coordination Organization (CCO), hospice or a voluntary foster care agency certified by the office of children and family services certified and licensed pursuant to article twenty-nine-i of this chapter;

* (x) certified peer recovery advocate services providers certified by the commissioner of addiction services and supports pursuant to section 19.18-b of the mental hygiene law, peer providers credentialed by the commissioner of addiction services and supports and peers certified or credentialed by the office of mental health;

* NB Effective until April 1, 2028

* (x) certified peer recovery advocate services providers certified by the commissioner of addiction services and supports pursuant to section 19.18-b of the mental hygiene law, peer providers credentialed by the commissioner of addiction services and supports and peers certified or credentialed by the office of mental health; and

* NB Effective April 1, 2028

* (y) a mental health practitioner licensed pursuant to article one hundred sixty-three of the education law; and

* NB Effective until April 1, 2028

* (y) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

* NB Effective April 1, 2028

* (z) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

* NB Effective until April 1, 2028

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth.

4. "Telehealth" means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. For purposes of this section, telehealth shall be limited to telemedicine, store and forward technology, remote patient monitoring and audio-only telephone communication, except that with respect to the medical assistance program established under section three hundred sixty-six of the social services law, and the child health insurance plan under title one-A of article twenty-five of this chapter, telehealth shall include audio-only telephone communication only to the extent defined in regulations as may be promulgated by the commissioner. This subdivision shall not preclude the delivery of health care services

by means of "home telehealth" as used in section thirty-six hundred fourteen of this chapter.

5. "Telemedicine" means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.

6. "Store and forward technology" means the asynchronous, electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.

7. "Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone. Such conditions shall include, but not be limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician licensed pursuant to article one hundred thirty-one of the education law, a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law, or a midwife licensed pursuant to article one hundred forty of the education law, with which the patient has a substantial and ongoing relationship.

§ 2999-dd. Telehealth delivery of services. * 1. Health care services delivered by means of telehealth shall be entitled to reimbursement

under section three hundred sixty-seven-u of the social services law on the same basis, at the same rate, and to the same extent the equivalent services, as may be defined in regulations promulgated by the commissioner, are reimbursed when delivered in person; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies set forth in section twenty-eight hundred seven of this chapter, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting; and further provided, however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation. Notwithstanding the provisions of this subdivision, for services licensed, certified or otherwise authorized pursuant to article sixteen, article thirty-one or article thirty-two of the mental hygiene law, such services provided by telehealth, as deemed appropriate by the relevant commissioner, shall be reimbursed at the applicable in person rates or fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports pursuant to article forty-three of the mental hygiene law.

* NB Effective until April 1, 2028

* 1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law; provided however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation.

* NB Effective April 1, 2028

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

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

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

4. Nothing in this article shall be deemed to allow any person to provide any service for which a license, registration, certification or other authorization under title eight of the education law is required and which the person does not possess.

§ 2999-ee. Increased application of telehealth. In order to increase the application of telehealth in behavioral health, oral health, maternity care, care management, services provided in emergency departments, and services provided to certain high-need populations to the extent such services are deemed appropriate for the populations

served, and notwithstanding the definitions set forth in section twenty-nine hundred ninety-nine-cc of this article, in consultation with the commissioner of the office of children and family services, the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities, as applicable, the commissioner may specify in regulation additional acceptable modalities for the delivery of health care services via telehealth, including but not limited to audio-only or video-only telephone communications, online portals and survey applications, and may specify additional categories of originating sites at which a patient may be located at the time health care services are delivered to the extent such additional modalities and originating sites are deemed appropriate for the populations served.

ARTICLE 29-I

MEDICAL SERVICES FOR FOSTER CHILDREN

Section 2999-gg. Voluntary foster care agency health facilities.

§ 2999-gg. Voluntary foster care agency health facilities. 1. In order for an authorized agency that is approved by the office of children and family services to care for or board out children, to provide limited health-related services as defined in regulations of the department either directly or indirectly through a contract arrangement, such agency shall obtain, in accordance with a schedule developed by the department in conjunction with the office of children and family services, a license issued by the commissioner in conjunction with the office of children and family services to provide such services. Such schedule shall require that all such authorized agencies operating on January first, two thousand nineteen obtain the license required by this section no later than January first, two thousand nineteen. Such licenses shall be issued in accordance with the standards set forth in this article and the regulations of the department which shall, at a minimum, specify: mandated health services, which shall include, but not be limited to, nursing and behavioral health services; general physical

environment requirements; minimum health and safety procedures; record management requirements; quality management activities; and managed care liaison, fiscal and billing activities. In determining the criteria for licensure, regulations shall take into account the size and type of each program, and shall be reasonably related to the provision of medical services. Provided however, that a license pursuant to this section shall not be required if such authorized agency is otherwise authorized to provide the required limited-health-related services to foster children under a license issued pursuant to article twenty-eight of this chapter or article thirty-one of the mental hygiene law. For the purposes of this section, the term authorized agency shall be an authorized agency as defined in paragraph (a) of subdivision ten of section three hundred seventy-one of the social services law.

2. Such license shall not be issued unless it is determined that the equipment, personnel, rules, standards of care and services are fit and adequate, and that the health-related services will be provided in the manner required by this article and the rules and regulations thereunder.

3. The commissioner and the commissioner of the office of children and family services shall enter into a memorandum of agreement for the purposes of administering the requirements of this section.

4. Proceedings involving the issuance of licenses for health-related services to authorized agencies:

(a) A license for health-related services under this article may be revoked, suspended, limited, annulled or denied by the commissioner, in consultation with the office of children and family services, if an authorized agency is determined to have failed to comply with the provisions of this article or the rules and regulations promulgated thereunder. No action taken against a license under this subdivision shall affect an authorized agency's license to care for or board children unless the commissioner of the office of children and family services determines, pursuant to the regulations of such office, that the existing circumstances make it necessary to limit, suspend or revoke the authority of the authorized agency to care for or board children.

(b) No such license shall be revoked, suspended, limited, annulled or denied without a hearing. However, a license may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice that the continuation of health-related services places the public health or safety of the recipients in imminent danger.

(c) The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the authorized agency at least twenty-one days before the date fixed for the hearing. The authorized agency shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(d) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant or agency.

ARTICLE 29-J

MEDICAL RESPITE PROGRAM

Section 2999-hh. Medical respite program.

§ 2999-hh. Medical respite program. 1. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly otherwise requires:

(a) "Medical respite program" means a not-for-profit corporation certified pursuant to subdivision two of this section to serve recipients whose prognosis or diagnosis necessitates the receipt of:

(i) Temporary room and board; and

(ii) The provision or arrangement of the provision of health care and support services; provided, however, that the operation of a medical respite program shall be separate and distinct from any housing programs offered to individuals who do not qualify as recipients.

(b) "Recipient" means an individual who:

- (i) Has a qualifying health condition that requires treatment or care;
- (ii) Does not require hospital inpatient, observation unit, or emergency room level of care, or a medically indicated emergency department or observation visit; and
- (iii) Is experiencing homelessness or at imminent risk of homelessness. A person shall be deemed "homeless" if they lack a fixed, regular and adequate nighttime residence in a location ordinarily used as a regular sleeping accommodation for people; provided, however, that an operator of a medical respite program shall be permitted to specialize by providing services to a subpopulation of homeless recipients if necessary to respond to community need or ensure the availability of a funding source that will support the medical respite program's operations, and such limitations are otherwise consistent with any rules or regulations made pursuant to this section.

2. Certification. (a) Notwithstanding any inconsistent provision of law, the commissioner may certify a not-for-profit corporation as an operator of a medical respite program.

(b) The commissioner may make regulations to establish procedures to review and approve applications for a certification pursuant to this article, which shall, at a minimum, specify standards for: recipient eligibility; medical respite program services that shall be provided; physical environment; staffing; and policies and procedures governing health and safety, length of stay, referrals, discharge, and coordination of care.

3. Operating standards; responsibility for standards. (a) Medical respite programs certified pursuant to this article shall:

- (i) Provide recipients with temporary room and board; and
- (ii) Provide, or arrange for the provision of, health care and support services to recipients.

(b) Nothing in this article shall affect the application, qualification, or requirements that may apply to an operator with respect to any other licenses or operating certificates that such operator may hold, including, without limitation, under article twenty-eight of this chapter or article seven of the social services law.

4. Temporary accommodation. A medical respite program shall be considered a form of emergency shelter or temporary shelter for purposes of determining a recipient's eligibility for housing programs or benefits administered by the state or by a local social services district, including programs or benefits that support access to accommodations of a temporary, transitional, or permanent nature. No claim of recovery shall accrue against a recipient to recover the cost of care and services provided under this article. Care and services provided under this article shall not be deemed public benefits that would affect a recipient's immigration status under federal law.

5. Inspections and compliance. The commissioner shall have the authority to inquire into the operation of any certified medical respite program and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care and services, system of accounts, records, and the adequacy of financial resources and sources of future revenues.

6. Suspension or revocation of certification. (a) A certification for a medical respite program may be revoked, suspended, limited, annulled or denied by the commissioner, in consultation with either the commissioners of the office of mental health, the office of temporary and disability assistance, or the office of addiction services and supports, as appropriate based on a determination of the department depending on the diagnosis or stated needs of the individuals being served or proposed to be served in the medical respite program, if an operator is determined to have failed to comply with this article or the rules and regulations made pursuant to this section. No action taken against an operator under this subdivision shall affect an operator's other licenses or certifications; provided however, that the facts that gave rise to the revocation, suspension, limitation, annulment or denial of certification may also form the basis of a limitation, suspension or revocation of such other licenses or certifications.

(b) No medical respite program certification shall be revoked, suspended, limited, annulled or denied without a hearing; provided that

a certification may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice that the continuation of the medical respite program places the health or safety of the recipients in imminent danger, and that the action is in the interest of the recipients. However, the department shall not make a determination until the program has had a reasonable opportunity, following the initial determination that the program places the health or safety of the recipients in imminent danger, to correct its deficiencies and following this period, which shall be up to thirty calendar days, has been given written notice and opportunity for hearing.

(c) Nothing in this section shall prevent the commissioner from imposing sanctions or penalties on a medical respite program that are authorized under any other law or regulation.

7. The commissioner shall promulgate regulations to implement this article.

ARTICLE 29-K

REGISTRATION OF TEMPORARY HEALTH CARE SERVICES AGENCIES AND HEALTH CARE TECHNOLOGY PLATFORMS

Section 2999-ii. Definitions.

2999-jj. Registration of temporary health care services agencies; requirements.

2999-kk. Temporary health care services agencies; minimum standards.

2999-ll. Violations; penalties.

2999-mm. Rates for temporary health care services; reports.

§ 2999-ii. Definitions. For the purposes of this article:

1. "Certified nurse aide" means a person included in the nursing home nurse aide registry pursuant to section twenty-eight hundred three-j of this chapter as added by chapter seven hundred seventeen of the laws of nineteen hundred eighty-nine.

* 2. "Controlling person" means a person, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a temporary health care services agency. "Controlling person" also means an individual who, directly owns at least ten percent voting interest in a corporation, partnership, or other business entity that is a controlling person.

* NB Effective until May 28, 2027

* 2. "Controlling person" means a person, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a temporary health care services agency. "Controlling person" also means a person who directly owns at least ten percent voting interest in a corporation, partnership, or other business entity that is a controlling person.

* NB Effective May 28, 2027

3. "Health care entity" means an agency, corporation, facility, or individual providing medical or health care services.

4. "Health care personnel" means nurses, certified nurse aides and licensed or unlicensed direct care staff provided by the temporary health care services agency to provide temporary services in a health care entity.

5. "Nurse" means a registered professional nurse, or a licensed practical nurse as defined by article one hundred thirty-nine of the education law.

6. "Direct care worker" means an individual who is responsible for patient/resident handling or patient/resident assessment as a regular or incidental part of their services, including any licensed or unlicensed health care worker.

7. "Person" means an individual, firm, corporation, partnership, or association.

* 8. "Temporary health care services agency" or "agency" means a person, firm, corporation, partnership, association or other entity in the business of providing or procuring temporary employment or engaging

individuals to provide health care services for health care entities, or of enabling health care entities to engage individuals to perform health care services. Temporary health care services agency shall include a nurses' registry licensed under article eleven of the general business law and entities that utilize apps or other technology-based solutions to provide, procure or enable health care entities to engage individuals to perform health care services. Temporary health care services agency shall not include: (a) an individual who only engages in providing the individual's own services on a temporary basis to health care entities; or (b) a home care agency licensed under article thirty-six of this chapter.

* NB Effective until May 28, 2027

* 8. "Temporary health care services agency" or "agency" means a person, firm, corporation, partnership, association or other entity in the business of providing or procuring temporary employment or engaging individuals to provide health care services for health care entities, or of enabling health care entities, directly or indirectly, to engage individuals to perform health care services. Temporary health care services agency shall include a nurses' registry licensed under article eleven of the general business law and entities that utilize apps or other technology-based solutions to provide, procure or enable health care entities to engage individuals to perform health care services, including vendor management systems and subcontracting arrangements with other agencies that result in the engagement of individuals. Temporary health care services agency shall not include: (a) an individual who only engages in providing the individual's own services on a temporary basis to health care entities; or (b) a home care agency licensed under article thirty-six of this chapter.

* NB Effective May 28, 2027

§ 2999-jj. Registration of temporary health care services agencies; requirements. 1. Any person who operates a temporary health care services agency shall register the agency with the department.

2. The commissioner shall publish guidelines establishing the forms and procedures for applications for registration. Forms must include, at

a minimum all of the following:

(a) The names and addresses of the temporary health care services agency controlling person or persons.

(b) The names and addresses of health care entities where the controlling person or persons or their family members:

(i) have an ownership relationship; or

(ii) direct the management or policies of such health care entities.

(c) A demonstration that the applicant is of good moral character and able to comply with all applicable state laws and regulations relating to the activities in which it intends to engage under the registration.

(d) Registration and registration annual renewal fees of one thousand dollars and shall only be used for the purpose of operating this registry.

(e) The state of incorporation of the agency.

(f) Any additional information that the commissioner determines is necessary to properly evaluate an application for registration.

* 3. As a condition of registration, a temporary health care services agency:

(a) Shall document that each individual engaged to provide health care services to health care entities currently meets the minimum licensing, training, and continuing education standards for the position in which the health care personnel will be working.

(b) Shall comply with all pertinent requirements and qualifications for personnel employed in health care entities.

(c) Shall not restrict in any manner the employment opportunities of its health care personnel.

(d) Shall not require the payment of liquidated damages, employment fees, or other compensation should the health care personnel be hired as a permanent employee of a health care entity in any contract with any health care personnel or health care entity or otherwise.

(e) Shall retain all records related to health care personnel for six calendar years and make them available to the department upon request.

(f) Shall comply with any requests made by the department to examine the books and records of the agency, subpoena witnesses and documents and make such other investigation as is necessary in the event that the department has reason to believe that the books or records do not accurately reflect the financial condition or financial transactions of

the agency.

(g) Shall comply with any additional requirements the department may deem necessary.

* NB Effective until May 28, 2027

* 3. As a condition of registration, a temporary health care services agency:

(a) Shall document that each individual engaged to provide health care services to health care entities currently meets the minimum licensing, training, and continuing education standards for the position in which the individual will be working.

(b) Shall comply with all pertinent requirements and qualifications for personnel employed in health care entities.

(c) Shall not restrict in any manner the employment opportunities of individuals it connects with health care entities to provide health care services.

(d) Shall not require the payment of liquidated damages, employment fees, or other compensation should the individuals it connects with health care entities to provide health care services be hired as a permanent employee, contractor, or contingent worker of a health care entity in any contract with any individual engaged to provide health care services or health care entity or otherwise.

(e) Shall not require the payment of fees or other compensation from the individual engaged to provide health care services for placement or connection with a health care entity.

(f) Shall retain all records related to individuals engaged to provide health care services for six years and make them available to the department upon request.

(g) Shall comply with any requests made by the department to examine the books and records of the agency, subpoena witnesses and documents and make such other investigation as is necessary in the event that the department has reason to believe that the books or records do not accurately reflect the financial condition or financial transactions of the agency.

(h) Shall comply with any additional requirements the department may deem necessary.

* NB Effective May 28, 2027

4. A registration issued by the commissioner according to this section shall be effective for a period of one year, unless the registration is revoked or suspended, or unless ownership interest of ten percent or more, or management of the temporary health care services agency, is sold or transferred. When ownership interest of ten percent or more, or management of a temporary health care services agency is sold or transferred, the registration of the agency may be transferred to the new owner or operator for thirty days, or until the new owner or operator applies and is granted or denied a new registration, whichever is sooner.

5. The commissioner may, after appropriate notice and hearing, suspend, revoke, or refuse to issue or renew any registration or issue any fines established pursuant to section twenty-nine hundred ninety-nine-ll of this article if the applicant fails to comply with this article or any guidelines, rules and regulations promulgated thereunder.

6. The commissioner shall make available a list of temporary health care services agencies registered with the department on the department's public website.

7. The department shall publish a quarterly report containing aggregated and de-identified data collected pursuant to this article on the department's website.

8. The department, in consultation with the department of labor, shall provide a report to the governor and legislature on or before January first, two thousand twenty-four, summarizing the key findings of the data collected pursuant to this article. The department shall further have authority to utilize any data collected pursuant to this article for additional purposes consistent with this chapter, including but not limited to determinations of whether an acute labor shortage exists, or any other purpose the department deems necessary for health care related data purposes.

9. The attorney general may, upon the request of the department, bring

an action for an injunction against any person who violates any provision of this article; provided, the department shall furnish the attorney general with such material, evidentiary matter or proof as may be requested by the attorney general for the prosecution of such action.

§ 2999-kk. Temporary health care services agencies; minimum standards.

1. A temporary health care services agency shall appoint an administrator qualified by training, experience or education to operate the agency. Each separate agency location shall have its own administrator.

* 2. A temporary health care services agency shall maintain a written agreement or contract with each health care entity, which shall include, at a minimum:

(a) The required minimum licensing, training, and continuing education requirements for each individual engaged in a health care position.

(b) Any requirement for minimum advance notice in order to ensure prompt arrival of individuals engaged to provide health care services.

(c) The maximum rates that can be billed or charged by the temporary health care services agency pursuant to section twenty-nine hundred ninety-nine-mm of this article and any applicable regulations.

(d) The rates to be charged by the temporary health care services agency.

(e) Procedures for the investigation and resolution of complaints about the performance of temporary health care services agency personnel.

(f) Procedures for notice from health care entities of failure of individuals engaged to provide health care services to report to an agreed upon scheduled shift.

(g) Procedures for notice of actual or suspected abuse, theft, tampering or other diversion of controlled substances by medical personnel.

(h) The types and qualifications of individuals engaged to provide health care services available through the temporary health care services agency.

* NB Effective until May 28, 2027

* 2. A temporary health care services agency shall maintain, and

require subcontracting arrangements with other agencies to maintain, a written agreement or contract with each health care entity, which shall include, at a minimum:

(a) The required minimum licensing, training, and continuing education requirements for each individual engaged in a health care position.

(b) Any requirement for minimum advance notice in order to ensure prompt arrival of individuals engaged to provide health care services.

(c) The maximum rates that can be billed or charged by the temporary health care services agency pursuant to section twenty-nine hundred ninety-nine-mm of this article and any applicable regulations.

(d) The rates to be charged by the temporary health care services agency.

(e) Procedures for the investigation and resolution of complaints about the performance of individuals engaged to provide health care services.

(f) Procedures for notice from health care entities of failure of individuals engaged to provide health care services to report to an agreed upon scheduled shift.

(g) Procedures for notice of actual or suspected abuse, theft, tampering or other diversion of controlled substances by individuals engaged to provide health care services.

(h) The types and qualifications of individuals engaged to provide health care services available through the temporary health care services agency.

* NB Effective May 28, 2027

* 3. A temporary health care services agency shall submit to the department copies of all contracts between the agency and a health care entity to which it assigns or otherwise connects individuals engaged to provide health care services, and copies of all invoices to health care entities personnel. Executed contracts must be sent to the department within five business days of their effective date and are not subject to disclosure under article six of the public officers law.

* NB Effective until May 28, 2027

* 3. A temporary health care services agency shall retain for six years and make available to the department upon request copies of all contracts between the agency or a third party with whom the agency is subcontracting and a health care entity to which it assigns or otherwise

connects individuals engaged to provide health care services, and copies of all invoices to health care entities. Executed contracts submitted upon request to the department are not subject to disclosure under article six of the public officers law.

* NB Effective May 28, 2027

4. The commissioner may promulgate regulations to implement the requirements of this section and to establish additional minimum standards for the operation of temporary health care services agencies, including but not limited to pricing, fees, administrative costs, profits, and business practices.

5. The commissioner may waive the requirements of this article during a declared state or federal public health emergency.

* **§ 2999-ll. Violations; penalties.** In addition to other remedies available by law, violations of the provisions of this article and any regulations promulgated thereunder shall be subject to penalties and fines pursuant to section twelve of this chapter; provided, however, that each violation committed by any health care personnel of a temporary health care services agency shall be considered a separate violation.

* NB Effective until May 28, 2027

* **§ 2999-ll. Violations; penalties.** In addition to other remedies available by law, violations of the provisions of this article and any regulations promulgated thereunder shall be subject to penalties and fines pursuant to section twelve of this chapter; provided, however, that each violation committed by a temporary health care services agency shall be considered a separate violation.

* NB Effective May 28, 2027

* **§ 2999-mm. Rates for temporary health care services; reports.** A temporary health care services agency shall report quarterly to the department a full disclosure of charges and compensation, including a schedule of all hourly bill rates per category of health care personnel,

a full description of administrative charges, and a schedule of rates of all compensation per category of health care personnel including, but not limited to:

1. hourly regular pay rate, shift differential, weekend differential, hazard pay, charge nurse add-on, overtime, holiday pay, travel or mileage pay, and any health or other fringe benefits provided;

2. the percentage of health care entity dollars that the agency expended on temporary personnel wages and benefits compared to the temporary health care services agency's profits and other administrative costs;

3. a list of the states and zip codes of their health care personnels' primary residences;

4. the names of all health care entities they have contracted within New York state;

5. the number of health care personnel of the temporary health care services agency working at each entity; and

6. any other information prescribed by the commissioner.

* NB Effective until May 28, 2027

* § 2999-mm. Rates for temporary health care services; reports. 1. A temporary health care services agency shall report quarterly to the department a full disclosure of charges and compensation, including a schedule of all hourly bill rates per category of individuals engaged to provide health care services, a full description of administrative charges, and a schedule of rates of all compensation per category of individuals engaged to provide health care services including, but not limited to:

- (a) hourly regular pay rate, shift differential, weekend differential, hazard pay, charge nurse add-on, overtime, holiday pay, travel or mileage pay, and any health or other fringe benefits provided;

- (b) the percentage of health care entity dollars that the agency expended on compensation, including, as applicable, benefits, to

individuals engaged to provide health care services compared to the temporary health care services agency's profits and other administrative costs;

(c) a list of the states and zip codes of the primary residences of individuals engaged to provide health care services;

(d) the names of all health care entities they or a third party with whom the agency is subcontracting have contracted within New York state;

(e) the number of individuals engaged to provide health care services by the temporary health care services agency working at each entity; and

(f) any other information prescribed by the commissioner.

2. The commissioner is hereby authorized to promulgate regulations to establish, monitor, and enforce a limitation on the amount that temporary health care services agencies or certain types or classes of such agencies may retain as profit from providing, procuring, or enabling health care entities to engage an individual to provide health care services, which for the purposes of this section shall be referred to as the "agency rate." In setting one or more agency rates, which can be expressed as a percentage or in another manner as determined by the department, the department shall take into consideration factors including but not limited to the ability to maintain sufficient staffing of the health care workforce, whether on a contract or permanent basis and across the range of needed professional titles and roles, in all geographic areas across the state. The department shall also engage in a periodic reassessment of any agency rates to ensure that they reflect current conditions and remain effective.

3. The commissioner shall publish guidelines establishing the forms and procedures for verification of compliance with an agency rate. In addition, a temporary health care services agency shall retain for six years and make available to the department upon request copies of all contracts, invoices, records, payroll information, and other documents necessary to determine compliance with the agency rate. The department is authorized to conduct audits of temporary health care services agencies as well as targeted investigations based on complaints or atypical reporting patterns.

4. Nothing in this article shall displace any generally applicable law relevant to temporary health care services agencies, including but not limited to sections three hundred forty-nine and three hundred ninety-six-r of the general business law.

* NB Effective May 28, 2027

ARTICLE 30

EMERGENCY MEDICAL SERVICES

Section 3000. Declaration of policy and statement of purpose.

3000-a. Emergency medical treatment.

3000-b. Automated external defibrillators: Public access providers.

3000-c. Epinephrine devices.

3000-d. Availability of resuscitation equipment in certain public places.

3000-e. Rescue inhaler treatment devices.

3000-f. Automated external defibrillator; camps and youth sports programs.

3001. Definitions.

3002. New York state emergency medical services council.

3002-a. State emergency medical advisory committee.

3003. Regional emergency medical services councils.

3003-a. EMS program agencies.

3003-b. Availability of ambulance service and advanced life support first response service to store and distribute blood and initiate and administer blood transfusions.

3004. Emergency medical services system and agency performance standards.

3004-a. Regional emergency medical advisory committees.

3005. Ambulance service certificates.

3005-a. Staffing standards; ambulance services and advanced life support first response services.

3005-b. Emergency medical technician five year re-certification demonstration program.

3006. Quality improvement program.

3006-a. Patient privacy.

- 3007. Notice of alternative destination.
- 3008. Applications for determinations of public need.
- 3009. Continuation of existing services.
- 3010. Area of operation; transfers.
- 3011. Powers and duties of the department and the commissioner.
- 3012. Enforcement.
- 3013. Immunity from liability.
- 3014. Construction.
- 3015. Separability.
- 3016. Continuance of rules and regulations.
- 3017. Emergency medical service, Suffolk county.
- 3018. Community-based paramedicine demonstration program.
- 3019. Department review of comprehensive county emergency medical system plans.
- 3020. Recruitment and retention.
- 3030. Advanced life support services.
- 3031. Advanced life support system.
- 3032. State emergency medical services task force.
- 3033. Rules and regulations.
- 3034. Rules and regulations.

§ 3000. Declaration of policy and statement of purpose. The furnishing of medical assistance in an emergency is a matter of vital concern affecting the public health, safety and welfare. Prehospital emergency medical care, the provision of prompt and effective communication among ambulances and hospitals and safe and effective care and transportation of the sick and injured are essential public health services.

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

standards for advanced life support first response services and ambulance services.

§ 3000-a. Emergency medical treatment. 1. Except as provided in subdivision six of section six thousand six hundred eleven, subdivision two of section six thousand five hundred twenty-seven, subdivision one of section six thousand nine hundred nine and sections six thousand five hundred forty-seven and six thousand seven hundred thirty-seven of the education law, any person who voluntarily and without expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill, or injured, shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such emergency treatment unless it is established that such injuries were or such death was caused by gross negligence on the part of such person. Nothing in this section shall be deemed or construed to relieve a licensed physician, dentist, nurse, physical therapist or registered physician's assistant from liability for damages for injuries or death caused by an act or omission on the part of such person while rendering professional services in the normal and ordinary course of his or her practice.

2. (i) Any person or entity that purchases, operates, facilitates implementation or makes available resuscitation equipment that facilitates first aid, an automated external defibrillator or an epinephrine device as required by or pursuant to law or local law, or that conducts training under section three thousand-c of this article, or (ii) a health care practitioner that prescribes, dispenses or provides an epinephrine device under section three thousand-c of this article, shall not be liable for damages arising either from the use of that equipment by a person who voluntarily and without expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or medical emergency, or from the use of defectively manufactured equipment; provided that this subdivision shall

not limit the person's or entity's, the emergency health care provider's, or other health care practitioner's liability for their own negligence, gross negligence or intentional misconduct.

§ 3000-b. Automated external defibrillators: Public access providers.

1. As used in this section, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(a) "Automated external defibrillator" means a medical device, approved by the United States food and drug administration, that is capable with or without intervention by an operator of: recognizing the presence or absence, in a patient, of ventricular fibrillation and rapid ventricular tachycardia; determining whether defibrillation should be performed on the patient; upon determining that defibrillation should be performed, automatically charging; and delivering an appropriate electrical impulse to the patient's heart to perform defibrillation.

(b) "Public access defibrillation provider" means a person, firm, organization or other entity possessing or operating an automated external defibrillator pursuant to this section.

2. A person, firm, organization or other entity may purchase, acquire, possess and operate an automated external defibrillator pursuant to this section. Operation of an automated external defibrillator under this section shall be authorized in accordance with regulations promulgated by the department.

3. A public access defibrillation provider in possession of an automated external defibrillator shall comply with the following requirements, in a manner prescribed by the department:

(a) The public access defibrillation provider shall provide training in the use of an automated external defibrillator and cardiopulmonary resuscitation consistent with standards approved by the department, including but not limited to programs developed or authorized by the department or determined by the department to be consistent with accepted standards of practice. At least one individual associated with the public access defibrillation provider shall be designated to receive such training and to be familiar with the operation and routine

maintenance of the automated external defibrillator.

(b) The public access defibrillation provider shall cause the automated external defibrillator to be maintained and tested according to applicable standards of the manufacturer and any appropriate government agency.

(c) (i) The public access defibrillation provider shall register the existence, location and type of any automated external defibrillator it possesses with the department.

(ii) The department shall establish and maintain an electronic database, accessible to the public, containing information collected under this paragraph. The database shall include the location and type of each automated external defibrillator reported to the department.

(d) Every use of an automated external defibrillator on a patient shall be immediately reported to the appropriate local emergency medical services system or public safety answering point.

(e) The public access defibrillator provider shall report data related to the use of automated external defibrillators to the department. When available, the department shall incorporate data related to patient health outcomes, response times, whether a bystander administered CPR or used an automated external defibrillator, and any other information deemed appropriate by the commissioner into statewide or regional quality improvement and cardiac arrest surveillance programs, including participation in nationally recognized registries, as determined by the department. Confidential patient information shall be deidentified prior to incorporation.

(f) The public access defibrillation provider shall post a sign or notice at the main entrance to the facility or building in which the automated external defibrillator is stored, indicating the location where any such automated external defibrillator is stored or maintained in such building or facility on a regular basis.

4. Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability and shall not constitute the unlawful practice of a profession under title VIII of the education law.

5. Any manufacturer, distributor, retailer, or reseller that sells or otherwise transfers an automated external defibrillator for use in this state shall, at the time of sale or transfer, provide the purchaser with written or electronic notice of applicable requirements under this section, including registration, maintenance, and reporting obligations, in a form prescribed by the department.

§ 3000-c. Epinephrine devices. 1. Definitions. As used in this section:

(a) "Eligible person or entity" means: (i) an ambulance service or advanced life support first response service; a certified first responder, firefighter in a county, city, town or village having a population of less than two million provided such county is not wholly located within a city with a population of more than one million, emergency medical technician, or advanced emergency medical technician, who is employed by or an enrolled member of any such service; (ii) a children's overnight camp as defined in subdivision one of section thirteen hundred ninety-two of this chapter, a summer day camp as defined in subdivision two of section thirteen hundred ninety-two of this chapter, a traveling summer day camp as defined in subdivision three of section thirteen hundred ninety-two of this chapter or a person employed by such a camp; (iii) a school district, board of cooperative educational services, county vocational education and extension board, charter school, and non-public elementary and secondary school in this state or any person employed by any such entity, or employed by a contractor of such an entity while performing services for the entity; (iv) a sports, entertainment, amusement, education, government, day care or retail facility; an educational institution, youth organization or sports league; an establishment that serves food; or a person employed by such entity; (v) a police officer or peace officer in a county, city, town or village having a population of less than two million provided such county is not wholly located within a city with a population of more than one million; (vi) forest rangers, park rangers and environmental conservation police officers; and (vii) any other person or entity designated or approved, or in a category designated or approved pursuant to regulations of the commissioner in consultation

with other appropriate agencies.

(b) "Epinephrine device" means an epinephrine delivery device or product approved by the federal food and drug administration and used for the automatic injection or administration of a premeasured dose of epinephrine into the human body for the purpose of emergency treatment of a person appearing to experience anaphylactic symptoms approved by the food and drug administration.

(c) "Health care practitioner" means a health care practitioner licensed, certified, or authorized to practice under title eight of the education law who is authorized thereby to administer drugs, and who is acting within the scope of such health care practitioner's practice.

2. Possession and use. (a) Any eligible person or entity may purchase, acquire, possess and use epinephrine devices for emergency treatment of a person appearing to experience anaphylactic symptoms, under this section.

(b) An eligible person or entity shall designate one or more individuals who have completed the training required by paragraph (c) of this subdivision to be responsible for the storage, maintenance, control, and general oversight of the epinephrine devices acquired by the eligible person or entity.

(c) No one may use an epinephrine device on behalf of an eligible person or entity unless they have successfully completed a training course in the use of epinephrine devices conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment or by an entity or individual approved by the commissioner, or is directed in a specific instance to use an epinephrine device by a health care practitioner. The training required by this paragraph shall include (i) how to recognize signs and symptoms of severe allergic reactions, including anaphylaxis; (ii) recommended dosage for adults and children; (iii) standards and procedures for the storage and administration of an epinephrine device; and (iv) emergency follow-up procedures.

(d) This section does not prohibit the use of an epinephrine device (i) by a health care practitioner or (ii) by a person acting pursuant to a lawful patient-specific prescription.

(e) Every eligible person and entity authorized to possess and use

epinephrine devices pursuant to this section shall use, maintain and dispose of such devices pursuant to regulations of the department.

(f) Nothing in this section shall require any eligible person or entity to acquire, possess, store, make available, or administer an epinephrine device, except as provided for in subdivision five-e of section two hundred twenty-five of this chapter.

3. Prescriptions. (a) A health care practitioner who is authorized to prescribe drugs may prescribe, dispense or provide an epinephrine device to or for an eligible person or entity by a non-patient-specific prescription.

(b) A pharmacist may dispense an epinephrine device pursuant to a non-patient-specific prescription under this subdivision.

(c) This subdivision does not limit any other authority a health care practitioner or pharmacist has to prescribe, dispense, provide or administer an epinephrine device.

4. Application of other laws. (a) Use of an epinephrine device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

(b) Purchase, acquisition, possession or use of an epinephrine device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or article thirty-three of this chapter.

(c) Any person otherwise authorized to sell or provide an epinephrine device may sell or provide it to a person or entity authorized to possess it pursuant to this section.

§ 3000-d. Availability of resuscitation equipment in certain public places. 1. For the purposes of this section, the following terms shall be defined as follows:

a. "Bar" means any establishment which is devoted to the sale and service of alcoholic beverages for on-premises consumption and in which the service of food, if served at all, is incidental to the consumption of such beverages.

b. "Health club" means any commercial establishment offering instruction, training or assistance and/or the facilities for the preservation, maintenance, encouragement or development of physical fitness or well-being. "Health club" as defined herein shall include, but not be limited to health spas, health studios, gymnasiums, weight control studios, martial arts and self-defense schools or any other commercial establishment offering a similar course of physical training.

c. "Owner or operator" means the owner, manager, operator or other person having control of an establishment.

d. "Public place" means a restaurant, bar, theater or health club.

e. "Restaurant" means any commercial eating establishment which is devoted, wholly or in part, to the sale of food for on-premises consumption.

f. "Resuscitation equipment" means: (i) an adult exhaled air resuscitation mask, for which the federal food and drug administration has granted permission to market, accompanied by a pair of disposable gloves, and (ii) a pediatric exhaled air resuscitation mask, for which the federal food and drug administration has granted permission to market, accompanied by a pair of disposable gloves.

g. "Theater" means a motion picture theater, concert hall, auditorium or other building used for, or designed for the primary purpose of, exhibiting movies, stage dramas, musical recitals, dance or other similar performances.

2. The owner or operator of a public place shall have available in such public place resuscitation equipment in quantities deemed adequate by the department. Such equipment shall be readily accessible for use during medical emergencies. Any information deemed necessary by the commissioner shall accompany the resuscitation equipment. Resuscitation equipment shall be discarded after a single use.

3. The owner or operator of a public place shall provide notice to patrons, by means of signs, printed material or other means of written communication, indicating the availability of resuscitation equipment for emergency use and providing information on how to obtain cardiopulmonary resuscitation training. The type, size, style, location and language of such notice shall be determined in accordance with rules, promulgated by the commissioner. In promulgating such rules, the commissioner shall take into consideration the concerns of the public places within the scope of this section. If the department shall make signs available pursuant to this subdivision, it may charge a fee to cover printing, postage and handling expenses.

4. Any owner or operator of a public place, his or her employee or other agent, or any other person who voluntarily and without expectation of monetary compensation renders emergency treatment using the resuscitation equipment required pursuant to this section, to a person who is unconscious, ill or injured, shall only be liable pursuant to section three thousand-a of this article.

5. Nothing contained in this section shall impose any duty or obligation on any owner or operator of a public place, his or her employee or other agent, or any other person to provide resuscitation assistance to the victim of a medical emergency.

6. Nothing in this section shall be construed to restrict the power of any county, city, town, or village to adopt and enforce additional local laws, ordinances, or regulations which comply with at least the minimum applicable standards set forth in this article.

§ 3000-e. Rescue inhaler treatment devices. 1. Definitions. As used in this section:

(a) "Eligible person or entity" means (i) an ambulance service or advanced life support first response service; a certified first responder, emergency medical technician, or advanced emergency medical technician, who is employed by or an enrolled member of any such service; (ii) a children's overnight camp as defined in subdivision one

of section thirteen hundred ninety-two of this chapter, a summer day camp as defined in subdivision two of section thirteen hundred ninety-two of this chapter, a traveling summer day camp as defined in subdivision three of section thirteen hundred ninety-two of this chapter or a person employed by such a camp; (iii) a school district, board of cooperative educational services, county vocational education and extension board, charter school, and non-public elementary and secondary school in this state or any person employed by any such entity, or employed by a contractor of such an entity while performing services for the entity; or (iv) a sports, entertainment, amusement, education, government, day care or retail facility; an educational institution, youth organization or sports league; an establishment that serves food; or a person employed by such entity; and (v) any other person or entity designated or approved, or in a category designated or approved pursuant to regulations of the commissioner in consultation with other appropriate agencies.

(b) "Rescue inhaler treatment device" means a device used for the self-administration of inhaled rescue medications into the human body for the purpose of emergency treatment of a person appearing to experience an asthmatic or other respiratory disease approved by the food and drug administration.

(c) "Health care practitioner" means a health care practitioner licensed, certified, or authorized to practice under title eight of the education law who is authorized thereby to administer drugs, and who is acting within the scope of his or her practice.

2. Possession and use. (a) Any eligible person or entity may purchase, acquire, possess and use rescue inhaler treatment devices for emergency treatment of a person appearing to experience asthmatic or other respiratory disease symptoms, under this section.

(b) An eligible person or entity shall designate one or more individuals who have completed the training required by paragraph (c) of this subdivision to be responsible for the storage, maintenance, control, and general oversight of the rescue inhaler treatment devices acquired by the eligible person or entity.

(c) No one may use a rescue inhaler treatment device on behalf of an eligible person or entity unless he or she has successfully completed a

training course in the use of rescue inhaler treatment devices conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment or by an entity or individual approved by the commissioner, or is directed in a specific instance to use a rescue inhaler treatment device by a health care practitioner. The training required by this paragraph shall include (i) how to recognize signs and symptoms of severe asthmatic or other respiratory disease reactions; (ii) recommended dosage for adults and children; (iii) standards and procedures for the storage and administration of a rescue inhaler treatment; and (iv) emergency follow-up procedures.

(d) This section does not prohibit the use of a rescue inhaler treatment device (i) by a health care practitioner or (ii) by a person acting pursuant to a lawful patient-specific prescription.

(e) Every eligible person and entity authorized to possess and use rescue inhaler treatment devices pursuant to this section shall use and maintain such devices pursuant to regulations of the department.

(f) Nothing in this section shall require any eligible person or entity to acquire, possess, store, make available, or administer a rescue inhaler treatment.

3. Prescriptions. (a) A health care practitioner who is authorized to prescribe drugs may prescribe, dispense or provide a rescue inhaler treatment device to or for an eligible person or entity by a non-patient-specific prescription.

(b) A pharmacist may dispense a rescue inhaler treatment pursuant to a non-patient-specific prescription under this subdivision.

(c) This subdivision does not limit any other authority a health care practitioner or pharmacist has to prescribe, dispense, provide or administer a rescue inhaler treatment device.

4. Application of other laws. (a) Use of a rescue inhaler treatment device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

(b) Purchase, acquisition, possession or use of a rescue inhaler treatment device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight

of the education law or article thirty-three of this chapter.

(c) Any person otherwise authorized to sell or provide a rescue inhaler treatment device may sell or provide it to a person or entity authorized to possess it pursuant to this section.

§ 3000-f. Automated external defibrillator; camps and youth sports programs. 1. As used in this section, unless the context clearly requires otherwise, the following terms have the following meanings:

(a) "Automated external defibrillator" shall have the meaning set forth in section three thousand-b of this article.

(b) "Camp" means a children's overnight camp, summer day camp, or traveling summer day camp, as such terms are defined in section thirteen hundred ninety-two of this chapter, that is subject to regulation by the department.

(c) "Youth sports program" means any league or recreation program organized to provide group athletic activity to individuals under seventeen years old or programs providing athletic activity for high school students regardless of the age of the participants of such programs. Public school athletic programs subject to the requirements of section nine hundred seventeen of the education law shall not be subject to the requirements of this section.

2. Within one hundred eighty days of the effective date of this section, each camp, and each youth sports program that either hosts or participates in games, matches, tournaments, leagues, or similar activities in which at least five teams are participating, shall establish an automated external defibrillator implementation plan describing how the camp or program will:

(a) make available an automated external defibrillator or describe reasonable access to an automated external defibrillator at every camp, game and practice; and

(b) use best efforts to ensure that there is at least one employee, volunteer, coach, umpire or other qualified adult who is present at each such camp, game and practice who has successfully completed a training course consistent with the standards approved by the department under the authority of section 3000-b of this article, within the preceding

twenty-four months of each such camp session, game and practice, and is familiar with the operation and routine maintenance of the automated external defibrillator.

(c) Each camp and youth sports program shall maintain records that such camp or youth sports program possesses at least one automated external defibrillator.

(d) Implementation plans shall include an equipment checklist and cardiac emergency protocol for when cardiac emergency incidents occur.

(e) Implementation plans can include automated external defibrillator access provided by athletic facilities, playing fields or site for games or practices where the operator of the facility provides automated external defibrillator access at their location.

3. Implementation of automated external defibrillator plans shall be done in accordance with the requirements and protections of section 3000-b of this article, including requirements as to maintenance, testing, and reporting usage and use-related data.

§ 3001. Definitions. As used in this article, unless the context otherwise requires:

1. "Emergency medical service" means initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.

2. "Ambulance service" means an individual, partnership, association, corporation, municipality or any legal or public entity or subdivision thereof engaged in providing emergency medical care and the transportation of sick or injured persons by motor vehicle, aircraft or other forms of transportation to, from, or between general hospitals or other health care facilities.

3. "Voluntary ambulance service" means an ambulance service (i) operating not for pecuniary profit or financial gain, and (ii) no part of the assets or income of which is distributable to, or enures to the benefit of, its members, directors or officers except to the extent

permitted under this article.

4. "Voluntary advanced life support first response service" means advanced life support first response service (i) operating not for pecuniary profit or financial gain, and (ii) no part of the assets or income of which is distributable to, or enures to the benefit of, its members, directors or officers except to the extent permitted under this article.

5. "Certified first responder" means an individual who meets the minimum requirements established by regulations pursuant to section three thousand two of this article and who is responsible for administration of initial life saving care of sick and injured persons.

6. "Emergency medical technician" means an individual who meets the minimum requirements established by regulations pursuant to section three thousand two of this article and who is responsible for administration or supervision of initial emergency medical care and transportation of sick or injured persons.

7. "Advanced emergency medical technician" means an emergency medical technician who has satisfactorily completed an advanced course of training approved by the state council under regulations pursuant to section three thousand two of this article.

8. "State council" means the New York state emergency medical services council established pursuant to this article.

9. "Regional council" means a regional emergency medical services council established pursuant to this article.

10. "Enrolled member" means any member of a voluntary ambulance service or voluntary advanced life support first response service who provides emergency medical care or transportation of sick or injured persons without expectation of monetary compensation.

11. "Advanced life support care" means definitive acute medical care

provided, under medical control, by advanced emergency medical technicians within an advanced life support system.

12. "Advanced life support system" means an organized acute medical care system to provide advanced life support care on site or en route to, from, or between general hospitals or other health care facilities.

13. "Advanced life support mobile unit" means an ambulance or advanced life support first response vehicle approved to provide advanced life support services pursuant to this article.

14. "Qualified medical and health personnel" means physicians, registered professional nurses and advanced emergency medical technicians competent in the management of patients requiring advanced life support care.

15. "Medical control" means: (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility; and (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state emergency medical services council and the commissioner, and implemented by regional medical advisory committees.

16. "Regional medical advisory committee" means a group of five or more physicians, and one or more non-voting individuals representative of each of the following: hospitals, basic life support providers, advanced life support providers and emergency medical services training sponsor medical directors approved by the affected regional emergency medical services councils.

17. "Advanced life support first response service" means an organization which provides advanced life support care, but does not transport patients.

18. "EMS program agency" means a not-for-profit corporation or municipality designated by the state council and approved by the affected regional council or councils to facilitate the development and operation of an emergency medical services system within a region as directed by the regional council under this article.

19. "Operator" means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of an ambulance service or advanced life support first response service.

20. "Mutual aid agreement" means a written agreement, entered into by two or more ambulance services or advanced life support first response services possessing valid ambulance service or advanced life support first response service certificates or statements of registration, for the organized, coordinated, and cooperative reciprocal mobilization of personnel, equipment, services, or facilities for back-up or support upon request as required pursuant to a written mutual aid plan. An ambulance service and advanced life support first response service may participate in one or more mutual aid agreements.

21. "Primary territory" means the geographic area or subdivisions listed on an ambulance service certificate or statement of registration within which the ambulance service may receive patients for transport.

§ 3002. New York state emergency medical services council. 1. There is hereby created in the department of health the New York state emergency medical services council. The state council shall consist of thirty-two members. Fourteen members to the state council shall be appointed by the commissioner and shall be representative of each geographic area of the state. At least one member shall be representative of the interests of the general public. Other members shall be knowledgeable in various aspects of emergency medical services and shall include, but not be limited to, representatives of voluntary ambulance services, advanced

life support first response services, ambulance services operating for profit, municipal ambulance services, hospitals, a statewide organization representing volunteer fire services, municipal tax districts providing ambulance services, physicians, and nurses. The commissioner shall also appoint a representative from each regional council, from nominations received from the appropriate regional council. The members of the state council shall elect a chairperson from among the members of the state council by a majority vote of those present, who shall serve for a term of one year and until a successor is elected.

1-a. The state emergency medical services council shall advise and assist the commissioner on such issues as the commissioner may require related to the provision of emergency medical service, specialty care, designated facility care, and disaster medical care. This shall include, but shall not be limited to, the recommendation, periodic revision, and application of rules and regulations, appropriateness review standards, treatment protocols, workforce development, and quality improvement standards. The state emergency medical services council shall meet at least three times per year or more frequently at the request of the chairperson or department and approved by the commissioner.

2. The state council shall have the power, by an affirmative vote of a majority of those present, subject to approval by the commissioner, to enact, and from time to time, amend and repeal, rules and regulations establishing minimum standards for ambulance services, ambulance service certification, advanced life support first response services, the provision of prehospital emergency medical care, public education, the development of a statewide emergency medical services system, the provision of ambulance services outside the primary territory specified in the ambulance services' certificate and the training, examination, and certification of certified first responders, emergency medical technicians, and advanced emergency medical technicians; provided, however, that such minimum standards must be consistent with the staffing standards established by section three thousand five-a of this article. Such training shall be made available by video or computer to the maximum extent possible. Until January first, nineteen hundred

ninety-seven, no minimum standards shall be established for services provided by a voluntary ambulance service operating solely pursuant to a statement of registration issued under section three thousand four. The curriculum for certified first responder training shall not exceed fifty-one hours including prerequisites. The state council shall have the same powers granted to regional councils by this article in any region of the state in which a regional council has not been established.

2-a. In furtherance of the powers set forth in subdivision two of this section, the state council shall provide to the trustees of the state university of New York such information and recommendations as may be requested by such trustees to assist such trustees' study of the feasibility of community colleges' and state university of New York agricultural and technical colleges' offering credit and noncredit courses which would satisfy the educational requirements for certification and recertification of emergency medical technicians and advanced emergency medical technicians.

2-b. The commissioner, in consultation with the state emergency medical services council, shall develop a program to allow certified first responders, emergency medical technicians and advanced emergency medical technicians who have been in continuous practice, who have demonstrated competence in applicable behavioral and performance objectives, and who have demonstrated completion of appropriate continuing education, to renew their certification under subdivision two of this section without requiring the completion of a written examination. In implementing this program, the commissioner shall contract with and use the standards established by a nationally recognized organization that certifies certified first responders, emergency medical technicians and advanced emergency medical technicians. Renewals of certification under the program shall be deemed equivalent to renewals under subdivision two of this section for purposes of this article.

3. Upon appeal from the appropriate regional council, the state council shall have the power, by an affirmative vote of a majority of

those present, to amend, modify and reverse determinations of the regional councils made pursuant to subdivision five of section three thousand three and section three thousand eight of this article. All determinations of the state council respecting applications for ambulance service certificates or statements of registration or respecting the revocation, suspension (except temporary suspension), limitation or annulment of an ambulance service certificate shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the determination upon the applicant or holder of the certificate.

3-a. Upon appeal from the applicant, the department, or any concerned party, the state council shall have the power, by an affirmative vote of a majority of those present, to amend, modify and reverse determinations of the regional councils made pursuant to subdivision five-a of section three thousand three of this article. All determinations of the state council with respect to exemptions shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail.

4. The term of office of each member shall be two years. Vacancies shall be filled by appointment for the remainder of an unexpired term. The members shall continue in office until the expiration of their terms and until their successors are appointed and have qualified. No member shall be appointed to the state council for more than four consecutive terms.

5. The state council shall meet as frequently as its business may require. The presence of a majority of the members shall constitute a quorum. The members of the state council shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

6. The commissioner, upon request of the state council, shall designate an officer or employee of the department to act as secretary of the state council, and shall assign from time to time such other employees as the state council may require.

7. No civil action shall be brought in any court against any member, officer or employee of the state council for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer or employee of the state council, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

8. The state council shall, after consultation with the department and the regional councils, forward to the commissioner not later than December first an estimate of the amounts needed to provide adequate funding for emergency medical services training including advanced life support at the local level, regional medical emergency services councils, emergency medical services program agencies, the state emergency medical services council or other emergency medical services training programs to carry out the purposes of this article and article thirty-A of this chapter. Such estimate shall be transmitted without change by the commissioner to the governor, the division of the budget, the temporary president of the senate, the speaker of the assembly, and the fiscal and health committees of each house of the legislature.

§ 3002-a. State emergency medical advisory committee. 1. There shall be a state emergency medical advisory committee of the state emergency medical services council consisting of thirty-one members. Twenty-three members shall be physicians appointed by the commissioner, including one nominated by each regional emergency medical services council, an additional physician from the city of New York, one pediatrician, one trauma surgeon, one psychiatrist and the chairperson. Each of the physicians shall have demonstrated knowledge and experience in emergency medical services. There shall be eight non-physician non-voting members

appointed by the chairperson of the state council, at least five of whom shall be members of the state emergency medical services council at the time of their appointment. At least one of the eight shall be an emergency nurse, at least one shall be an advanced emergency medical technician, at least one shall be a basic emergency medical technician, and at least one shall be employed in a hospital setting with administrative responsibility for a hospital emergency department or service.

2. The committee shall develop and recommend to the state council statewide minimum standards for: (a) medical control; (b) treatment, transportation and triage protocols, including protocols for invasive procedures and infection control; and (c) the use of regulated medical devices and drugs by emergency medical services personnel certified pursuant to this article. The state emergency medical advisory committee, with the consent of the commissioner, may issue advisory guidelines in any of these areas, which shall not have the force and effect of law unless adopted as rules and regulations by the state emergency medical services council. The state emergency medical advisory committee shall advise the state emergency medical services council prior to the issuance of any guidelines. The committee shall also review protocols developed by regional emergency medical advisory committees for consistency with statewide standards.

2-a. Any decision of the state emergency medical advisory committee regarding medical control, protocols for treatment, triage, or transportation, or the use of regulated medical devices may be appealed to the commissioner by any required regional emergency medical services council, regional emergency medical advisory committee, ambulance service or advanced life support service, or certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected.

3. Each member shall have a term of two years, except that five of those first appointed shall have a term of three years. Members may succeed themselves.

4. The committee shall meet as frequently as its business may require. The presence of a majority of the members shall constitute a quorum. The members of the committee shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

5. No civil action shall be brought in any court against any member, officer or employee of the committee for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the committee, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer, or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

§ 3003. Regional emergency medical services councils. 1. The commissioner, with the approval of the state council, shall designate regional emergency medical services councils on or before January first, nineteen hundred seventy-eight but in no event shall the number of regional councils exceed eighteen. Such regional councils shall be established on the basis of application for designation as regional councils submitted by local organizations, the members of which are knowledgeable in various aspects of emergency medical services. Such application shall describe the geographic area to be served and contain a list of nominees for appointment to membership on such regional councils and a statement as to the proposed method of operation in such detail as the commissioner, with the approval of the state council, shall prescribe.

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

as outlined by the state emergency medical services council with approval of the department.

2. Each regional council shall be comprised of at least fifteen but not more than thirty members to be initially appointed by the commissioner, with the approval of the state council, from nominations submitted by local organizations applying for establishment as the regional council. Not less than one-third of the membership of the regional councils shall be representatives of ambulance services and the remaining membership of the regional councils shall consist of, but not be limited to, representatives of existing local emergency medical care committees, physicians, nurses, hospitals, health planning agencies, fire department emergency and rescue squads, public health officers and the general public. The county EMS coordinator, established pursuant to section two hundred twenty-three-b of the county law, of any county within the region shall serve as an ex officio member of the regional council; provided, however, nothing in this subdivision shall prevent a county EMS coordinator from serving as a voting member of a regional council. Members of each regional council shall be residents living within the geographic area to be served by the regional council. The presence of a majority of members shall constitute a quorum.

3. Each regional council shall have the power to:

(a) have a seal and alter the same at pleasure;

(b) acquire, lease, hold, and dispose of real and personal property or any interest therein for its purposes;

(c) make and alter by-laws for its organization and internal management, and rules and regulations governing the exercise of its powers and the fulfillment of its purposes under this article; such rules and regulations must be filed with the secretary of state and the state EMS council;

(d) enter into contracts for employment of such officers and employees as it may require for the performance of its duties; and to fix and determine their qualifications, duties, and compensation, and to retain and employ such personnel as may be required for its purposes; and private consultants on a contract basis or otherwise, for the rendering of professional or technical services and advice;

(e) enter into contracts, leases, and subleases and to execute all instruments necessary or convenient for the conduct of its business, including contracts with the commissioner and any state agency or municipal entity; and contracts with hospitals and physicians for the purposes of carrying out its powers under this article;

(f) undertake or cause to be undertaken plans, surveys, analyses and studies necessary, convenient or desirable for the effectuation of its purposes and powers, and to prepare recommendations and reports in regard thereto;

(g) fix and collect reasonable fees, rents, and other charges for the use of its equipment and the provision of its services;

(h) contract for and to accept any gifts or grants, subsidies, or loans of funds or property, or financial or other aid in any form from the federal or state government or any agency or instrumentality thereof; or from any other source, public or private, and to comply, subject to the provisions of this article, with the terms and conditions thereof; provided, however, that the councils may contract for payment of debt evidenced by bonds or notes or other evidence of indebtedness, either directly or through a lease purchase agreement;

(i) recommend to the department approval of training course sponsors within its region, and to develop, promulgate and implement annually an EMS training plan which addresses the needs of its region;

(j) enter into contracts or memoranda of agreement with other regional councils to provide services in a joint or cooperative manner; and to enter into contracts or memoranda of agreement with an EMS program agency to carry out one or more of its responsibilities under this article;

(k) procure insurance against any loss or liability in connection with the use, management, maintenance, and operation of its equipment and facilities, in such amounts and from such insurers as it reasonably deems necessary;

(l) approve regional medical advisory committee nominees;

(m) provide focused technical assistance and support to those voluntary ambulance services operating under exemptions, to assist such services in progressing toward the uniform standards established pursuant to this section. Such assistance and support shall include, but not be limited to, volunteer recruitment and management training; and

(n) do all things necessary, convenient and desirable to carry out its purposes and for the exercise of the powers granted in this article.

4. Each regional council shall have the responsibility to coordinate emergency medical services programs within its region, including but not limited to, the establishment of emergency medical technician courses and the issuance of uniform emergency medical technician insignia and certificates. Such training courses shall be made available by video or computer to the maximum extent possible.

5. The regional council shall have the responsibility to make determinations of public need for the establishment of additional emergency medical services and ambulance services and to make the determinations of public need as provided in section three thousand eight. The regional council shall make such determination by an affirmative vote of a majority of all of those members consisting of voting members.

5-a. The regional emergency medical services council is authorized to grant an exemption from the staffing standards set forth in section three thousand five-a of this article to a voluntary ambulance service operating solely with enrolled members or paid emergency medical technicians which has demonstrated a good faith effort to meet the standards and is unable to meet such standards because of factors deemed appropriate by the regional council. An exemption shall be for a period not to exceed two years and shall be conditioned on the participation by the voluntary service in a program to achieve compliance which shall include technical assistance and support from the regional council tailored to the needs and resources at the local level, as provided by paragraph (m) of subdivision three of this section, to be funded by the New York state emergency medical services training account established pursuant to section ninety-seven-q of the state finance law, such account as funded by a chapter of the laws of nineteen hundred ninety-three. Nothing shall prevent the regional council from issuing subsequent exemptions. Such exemptions shall have no effect whatsoever on the insurability of the organization receiving such exemption and such exemption shall not be used as a basis for increasing insurance

rates or premiums related thereto, notwithstanding any other provision of law, rule, regulation, or commissioner's ruling or advisory to the contrary. Prior to issuing an exemption, the regional council shall provide written notice by certified mail to the chief executive officers of all general hospitals and municipalities in the county or counties within which the service requesting an exemption operates. Such notice shall provide opportunity for comment on the issuance of the exemption. Notice of the determination of the regional council shall be provided within ten days of the determination to the applicant, the department, and any party receiving notification of the application who requests notice of the determination. The applicant, the department, or any concerned party may appeal the determination of the regional council to the state council within thirty days after the regional council makes its determination.

6. The term of office of members of the regional council shall be four years, except that of those members first appointed, at least one-half but not more than two-thirds shall be for terms not to exceed two years.

7. Each regional council shall meet as frequently as its business may require.

8. The commissioner, upon request of the regional council, may designate an officer or employee of the department to act as secretary of the regional council, and may assign from time to time such other employees as the regional council may require.

9. No civil action shall be brought in any court against any member, officer or employee of any designated regional council for any act done, failure to act, or statement or opinion made, while discharging his duties as a member, officer or employee of the regional council, without leave from a justice of the supreme court, first had and obtained. In any event such member, officer or employee shall not be liable for damages in any such action if he shall have acted in good faith, with reasonable care and upon probable cause.

10. (a) The department shall provide each regional council with the

funds necessary to enable such regional council to carry out its responsibilities as mandated under this section within amounts appropriated therefor.

(b) Such funds shall be provided upon approval by the department of an application submitted by a regional council. The application shall contain such information and be in such form as the commissioner shall require pursuant to rules and regulations which he shall promulgate after consultation with the state council in order to effect the purposes and provisions of this subdivision.

§ 3003-a. EMS program agencies. 1. As provided by agreement with the commissioner or regional councils based on needs identified by the regional emergency medical services councils, an EMS program agency may be responsible for facilitating quality improvement of emergency medical care within its region, staffing the regional emergency medical advisory committees provided for in section three thousand four-a of this article, providing prehospital education programs approved by the department, and other activities to support and facilitate regional emergency medical services systems.

2. The programs developed by the agencies established by subdivision one of this section shall be implemented beginning in nineteen hundred ninety-three using funds collected by the New York state emergency medical services training account, established within the miscellaneous special revenue fund - 339 by section ninety-seven-q of the state finance law.

3. The portion of the funds collected by the emergency medical services training New York state account, established and allocated within the miscellaneous special revenue fund - 339 by section ninety-seven-q of the state finance law, shall be adequate to support the costs incurred in implementing the programs described in subdivision one of this section.

§ 3003-b. Availability of ambulance service and advanced life support

first response service to store and distribute blood and initiate and administer blood transfusions. 1. An ambulance service or advanced life support first response service licensed under this article may store and distribute human blood and blood products at all their facilities and qualified medical and health personnel, as defined in this article, operating within an ambulance service or advanced life support first response service licensed under this article, may initiate and administer human blood and blood product transfusions while providing ambulance services or advanced life support care via an advanced life support mobile unit. As used in this section, " ambulance services" means emergency medical care and the transportation of sick or injured persons by motor vehicle or aircraft to, from or between general hospitals or other health care facilities.

2. Notwithstanding title five of article five of this chapter, any ambulance service or advanced life support first response service licensed under this article may store and distribute human blood and blood products in accordance with standards for the storage of blood products of the United States Food and Drug Administration and any rules, regulations, guidance or minimum standards established pursuant to this section.

3. Prior to storing and distributing blood or allowing qualified medical and health personnel to initiate and administer blood transfusions under this section, the ambulance service or advanced life support first response service shall ensure that it is in compliance with the rules, regulations, guidance or minimum standards established pursuant to this section and other applicable emergency medical service requirements, and shall provide notification of intent to store and distribute blood or allow qualified medical and health personnel to initiate and administer blood transfusions as part of their ambulance services or advanced life support care at least sixty days prior to beginning such care.

4. The state emergency medical services council, with the approval of the commissioner, shall promulgate rules and regulations to effectuate the purposes of this section.

§ 3004. Emergency medical services system and agency performance standards. 1. The state emergency medical services council and with input from the regional emergency medical services councils, in collaboration and with final approval of the department, shall create an emergency medical services system and agency performance standards (hereinafter referred to as "performance standards") for the purpose of sustaining and evolving a reliable emergency medical services system including but not limited to emergency medical services agencies and any facility or agency that dispatches or accepts emergency medical services resources.

2. The performance standards may include but shall not be limited to: safety initiatives, emergency vehicle operations, operational competencies, planning, training, onboarding, workforce development and engagement, survey responses, leadership and other standards and metrics as determined by the state emergency medical services council, with approval of the department, to promote positive patient outcomes, safety, provider retention and emergency medical services system sustainability throughout the state.

3. The performance standards shall require each emergency medical services agency, dispatch agency or facility that accepts emergency medical services resources to perform regular and periodic review of the performance standards and its metrics, perform surveys, identification of agency deficiencies and strengths, development of programs to improve agency metrics, strengthen system sustainability and operations, and improve the delivery of patient care.

4. The department, after consultation with the state emergency medical services council and with input from regional emergency medical services councils, may contract for services with subject matter experts to assist in the oversight of the performance standards statewide.

5. Emergency medical services agencies that do not meet the performance standards set forth in this section may be subject to

enforcement actions, including but not limited to revocation, suspension, performance improvement plans, or restriction from specific types of response including but not limited to suspension of ability to respond to requests for emergency medical assistance or to perform emergency medical services.

§ 3004-a. Regional emergency medical advisory committees. 1. Regional emergency medical advisory committees shall develop policies, procedures, and triage, treatment, and transportation protocols which are consistent with the standards of the state emergency medical advisory committee and which address specific local conditions. Regional emergency medical advisory committees may also approve physicians to provide on line medical control, coordinate the development of regional medical control systems, and participate in quality improvement activities addressing system-wide concerns. Hospitals and prehospital medical care services shall be authorized to release patient outcome information to regional emergency medical advisory committees for purposes of assessing prehospital care concerns. Regional quality improvement programs shall be presumed to be an extension of the quality improvement program set forth in section three thousand six of this article, and the provisions of subdivisions two and three of such section three thousand six shall apply to such programs.

2. The committee shall nominate to the commissioner a physician with demonstrated knowledge and experience in emergency medical services to serve on the state emergency medical advisory committee.

3. No civil action shall be brought in any court against any member, officer or employee of the committee for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the committee, without leave from a justice of the supreme court, first had and obtained. In no event shall such member, officer, or employee be liable for damages in any such action if he or she shall have acted in good faith, with reasonable care and upon probable cause.

4. Any decision of a regional emergency medical advisory committee regarding provision of a level of care, including staffing requirements, may be appealed to the state emergency medical advisory committee by any regional EMS council, ambulance service, advanced life support service, certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected. No action shall be taken to implement a decision regarding existing levels of care or staffing while an appeal of such decision is pending. Any decision of the state emergency medical advisory committee may be appealed pursuant to subdivision two-a of section three thousand two-a of this article.

§ 3005. Ambulance service certificates. 1. No ambulance service operating for profit, hospital ambulance service or municipal ambulance service of a city of over one million population shall operate on or after September first, nineteen hundred seventy-five unless it possesses a valid ambulance service certificate issued pursuant to this article. Effective January first, nineteen hundred ninety-seven, no ambulance service shall be operated unless it possesses a valid ambulance service operating certificate issued pursuant to this article or has been issued a statement of registration. No advanced life support first response service shall operate unless it possesses a valid advanced life support first responder service operating certificate. Effective January first, two thousand, no ambulance service shall be operated unless it possesses a valid operating certificate.

2. The department shall issue an initial certificate to an ambulance service certified prior to the effective date of this section upon submission of proof that it is the holder of a valid ambulance service certificate and is otherwise in compliance with provisions of section three thousand nine of this article.

2-a. Prior to January first, two thousand, the department shall issue an initial certificate to a registered ambulance service in possession of a valid registration provided that such service has been issued an exemption issued by a regional council pursuant to subdivision five-a of section three thousand three of this article.

3. The department shall issue an initial certificate to an advanced life support first response service upon submission of proof that such advanced life support first response service is staffed and equipped in accordance with rules and regulations promulgated pursuant to this article and is otherwise in compliance with provisions of section three thousand nine of this article.

4. A certificate issued to an ambulance service or advanced life support first response service shall be valid for two years. The initial certification fee shall be one hundred dollars. Thereafter the biennial fee shall be in accordance with the schedule of fees established by the commissioner pursuant to this article. However, there shall be no initial or renewal certification fee required of a voluntary ambulance service or voluntary advanced life support first response service.

5. No initial certificate (except initial certificates issued pursuant to subdivision two of this section) shall be issued unless the commissioner finds that the proposed operator or operators are competent and fit to operate the service and that the ambulance service or advanced life support first response service is staffed and equipped in accordance with rules and regulations promulgated pursuant to this article.

6. No ambulance service or advanced life support first response service shall begin operation without prior approval of the appropriate regional council, or if there is no appropriate regional council established such ambulance service or advanced life support first response service shall apply for approval from the state council as to the public need for the establishment of additional ambulance service or advanced life support first response service, pursuant to section three thousand eight of this article.

7. Applications for a certificate shall be made by the owner of an ambulance service or advanced life support first response service operating for profit or the responsible official of a voluntary ambulance service or advanced life support first response service upon

forms provided by the department. The application shall state the name and address of the owner and such other information as the department may require pursuant to rules and regulations.

8. For purposes of this article, competent means that any proposed operator of any ambulance service or advanced life support first response service who is already or had been within the last ten years an incorporator, director, sponsor, principal stockholder, or operator of any ambulance service, hospital, private proprietary home for adults, residence for adults, or non-profit home for the aged or blind which has been issued an operating certificate by the state department of social services, or a halfway house, hostel, or other residential facility or institution for the care, custody, or treatment of the mentally disabled subject to the approval by the department of mental hygiene, or any invalid coach service subject to approval by the department of transportation, is rendering or did render a substantially consistent high level of care. For purposes of this subdivision, the state emergency medical services council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to define substantially consistent high level of care with respect to ambulance services, advanced life support first response services, and invalid coaches, except that the commissioner may not find that a consistently high level of care has been rendered where there have been violations of the state EMS code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety, or welfare of any patient, and (ii) were recurrent or were not promptly corrected. For purposes of this article, the rules adopted by the state hospital review and planning council with respect to subdivision three of section twenty-eight hundred one-a of this chapter shall apply to other types of operators. Fit means that the operator or proposed operator (a) has not been convicted of a crime or pleaded nolo contendere to a felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or sale of drugs and (b) is not or was not subject to a state or federal administrative order relating to fraud or embezzlement, unless the commissioner finds that such conviction or such order does not demonstrate a present risk or danger to patients or the public.

§ 3005-a. Staffing standards; ambulance services and advanced life support first response services. 1. The following staffing standards shall be in effect unless otherwise provided by this section:

(a) effective January first, nineteen hundred ninety-seven the minimum staffing standard for a registered ambulance service shall be a certified first responder with the patient;

(b) effective January first, two thousand, the minimum staffing standard for a voluntary ambulance service shall be an emergency medical technician with the patient;

(c) the minimum staffing standard for all other ambulance services shall be an emergency medical technician with the patient; and

(d) the minimum staffing standard for an advanced life support first response service shall be an advanced emergency medical technician with the patient. Circumstances permitting other than advanced life support care by an advanced life support first response service may be established by rule by the state council, subject to the approval of the commissioner.

2. Any service granted an exemption by the regional council pursuant to subdivision five-a of section three thousand three of this article shall be subject to the standards and terms of the exemption.

3. Notwithstanding any other provision of this article, the effective date of the standards established by this section shall be delayed by one year for each fiscal year, prior to January first, two thousand, in which the amounts appropriated are less than that which would have been expended pursuant to the provisions of section ninety-seven-q of the state finance law.

*** § 3005-b. Emergency medical technician five year re-certification demonstration program.** 1. There is hereby created within the department a demonstration program (referred to in this section as the "program") to allow emergency medical technicians and advanced emergency medical technicians who have been in continuous practice and who have

demonstrated competence in applicable behavioral and performance objectives, to be re-certified for a five year period. No person shall be re-certified under the program unless he or she has completed at least one hundred thirty hours of instruction in emergency medical services as approved by the commissioner including but not limited to pediatrics, geriatrics, environmental emergencies, legal issues, emergency vehicle operations course and medical emergencies. Renewals of certification under the program shall be deemed equivalent to renewals under subdivision two of section three thousand two of this article.

2. The program shall be limited to persons who are employed by the New York city fire department or who are in practice in the following counties: Delaware, Fulton, Hamilton, Montgomery, Nassau, Otsego, Schoharie or Suffolk. The commissioner may limit the number of participants in the program, except that such limit shall be no less than four thousand participants.

3. Within a year after implementing the program and annually thereafter, the commissioner shall report to the governor and the legislature on the impact of the program on the quality of patient care and the effectiveness of the program in retaining and recruiting certified emergency medical technicians and advanced emergency medical technicians.

4. The commissioner, in consultation with the state emergency medical services council, shall make regulations necessary to implement this section.

* NB Repealed July 1, 2028

§ 3006. Quality improvement program. 1. By January first, nineteen hundred ninety-seven, every ambulance service and advanced life support first response service shall establish or participate in a quality improvement program, which shall be an ongoing system to monitor and evaluate the quality and appropriateness of the medical care provided by the ambulance service or advanced life support first response service, and which shall pursue opportunities to improve patient care and to

resolve identified problems. The quality improvement program may be conducted independently or in collaboration with other services, with the appropriate regional council, with an EMS program agency, with a hospital, or with another appropriate organization approved by the department. Such program shall include a committee of at least five members, at least three of whom do not participate in the provision of care by the service. At least one member shall be a physician, and the others shall be nurses, or emergency medical technicians, or advanced emergency medical technicians, or other appropriately qualified allied health personnel. The quality improvement committee shall have the following responsibilities:

- (a) to review the care rendered by the service, as documented in prehospital care reports and other materials. The committee shall have the authority to use such information to review and to recommend to the governing body changes in administrative policies and procedures, as may be necessary, and shall notify the governing body of significant deficiencies;

- (b) to periodically review the credentials and performance of all persons providing emergency medical care on behalf of the service;

- (c) to periodically review information concerning compliance with standard of care procedures and protocols, grievances filed with the service by patients or their families, and the occurrence of incidents injurious or potentially injurious to patients. A quality improvement program shall also include participation in the department's prehospital care reporting system and the provision of continuing education programs to address areas in which compliance with procedures and protocols is most deficient and to inform personnel of changes in procedures and protocols. Continuing education programs may be provided by the service itself or by other organizations; and

- (d) to present data to the regional medical advisory committee and to participate in system-wide evaluation.

2. The information required to be collected and maintained, including information from the prehospital care reporting system which identifies an individual, shall be kept confidential and shall not be released except to the department or pursuant to section three thousand four-a of this article.

3. Notwithstanding any other provisions of law, none of the records, documentation, or committee actions or records required pursuant to this section shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided in any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition related to disclosure of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject of which was reviewed at the meeting. The prohibition of disclosure of information from the prehospital care reporting system shall not apply to information which does not identify a particular ambulance service or individual.

4. Any person who in good faith and without malice provides information to further the purpose of this section or who, in good faith and without malice, participates on the quality improvement committee shall not be subject to any action for civil damages or other relief as a result of such activity.

§ 3006-a. Patient privacy. 1. As used in this section:

(a) "Individual identifying information" means information identifying or tending to identify a patient.

(b) "Marketing" means advertising, detailing, marketing, promotion, or any other activity that is intended to be used to influence business volume, sales or market share or evaluate the effectiveness of marketing practices or marketing personnel, regardless of whether the beneficiary of the marketing is a governmental, for-profit, or not-for-profit entity.

2. No ambulance service, advanced life support first response service, or employee, member or agent thereof shall disclose, sell, transfer, exchange, provide or use any individual identifying information to any person or entity for the purpose of marketing.

3. Notwithstanding subdivision two of this section, and subject to otherwise applicable law, individual identifying information may be:

(a) disclosed, sold, transferred or exchanged to:

(i) the patient who is the subject of the information, or a person authorized to make health care decisions for the patient;

(ii) a health care provider providing care or treatment to the patient, for the purpose of such care or treatment; or a health information system subject to regulations of the department, for the purpose of such care or treatment;

(iii) an officer, inspector or investigator for a government health, licensing or law enforcement agency acting under appropriate legal authority;

(iv) a person authorized by a court order or a subpoena to receive such information;

(v) the patient's health plan, insurer, or third party payer, or an agent thereof, for the purpose of payment or reimbursement for health care services, including determining compliance with the terms of coverage or medical necessity, or utilization review;

(vi) a person or entity to whom, and for a purpose for which, disclosure or transfer is otherwise explicitly authorized or required by law;

(vii) a person or entity, for the purpose of conducting quality assurance or evaluating the performance of an ambulance service, advanced life support first response service, or any employee, member or agent thereof;

(viii) a person or entity acting as an employee or agent of a person or entity under any preceding paragraph of this subdivision, for the purpose of and consistent with that paragraph; or

(ix) a government entity as provided by law; and

(b) used by such ambulance service, advanced life support first responder service, or employee, member or agent thereof, for training, promotion, staff recognition or recruitment purposes, consistent with applicable law, provided the patient or a qualified person as defined by paragraph (G) of subdivision one of section eighteen of this chapter has provided consent to such use in a separate, stand-alone document. Such consent shall be limited to the particular type or types of use and specific transaction or transactions for which such consent is given.

4. Nothing in this section shall prohibit the collection, use, transfer, or sale of patient data by zip code, geographic region, or medical specialty for marketing purposes, providing it does not contain individual identifying information.

5. This section shall not prevent a person from disclosing, selling, transferring, or exchanging for value his or her own individual identifying information, for any purpose; provided that the information does not include individual identifying information pertaining to any other person.

6. This section does not prohibit a not-for-profit or governmental ambulance service or advanced life support first response service, or agent thereof, from using a patient's name and address in order to contact such patient or a family member at such address with requests for donations to such service; providing that such use shall not include disclosing any individual identifying information.

7. No person or entity to whom or which individual identifying information is disclosed, sold, transferred or exchanged shall disclose, sell, transfer or exchange it to any person or entity other than for the lawful purpose for which it was disclosed, sold, transferred or exchanged to the person or entity, and without satisfactory assurance that the recipient will safeguard the records from being disclosed or used for marketing purposes.

8. This section does not authorize any disclosure, sale, transfer, or exchange of individual identifying information that is not otherwise authorized or required by law.

9. In addition to the commissioner's authority to enforce this section under section three thousand twelve of this article, the attorney general shall have the authority to bring an action to enforce compliance with this section without referral by the commissioner.

§ 3007. Notice of alternative destination. In any city having a population of one million or more, whenever an individual is transported by ambulance from one facility to a second facility and the destination is changed, it shall be the responsibility of the senior ambulance dispatcher to inform the facility of origin by telephone of the ultimate destination immediately upon arrival thereat.

§ 3008. Applications for determinations of public need. 1. Every application for a determination of public need shall be made in writing to the appropriate regional council, shall specify the primary territory within which the applicant requests to operate, be verified under oath, and shall be in such form and contain such information as required by the rules and regulations promulgated pursuant to this article.

2. Notice of the application shall be forwarded by registered or certified mail by the appropriate regional council to the chief executive officers of all general hospitals, ambulance services, and municipalities operating within the same county or counties where the services seeks to operate. The notice shall provide opportunity for comment.

3. Notice pursuant to this section shall be deemed filed with the ambulance service and municipality upon being mailed by the appropriate regional or state council by registered or certified mail.

4. The appropriate regional council or the state council shall make its determination of public need within sixty days after receipt of the application.

5. The applicant or any concerned party may appeal the determination of the appropriate regional council to the state council within thirty days after the regional council makes its determination.

6. In the case of an application for certification under this article by a municipal ambulance service to serve the area within the municipality, and the municipal ambulance service meets appropriate

training, staffing and equipment standards, there should be a presumption in favor of approving the application.

7. (a) Notwithstanding any other provision of law and subject to the provisions of this article, any municipality within this state, or fire district acting on behalf of any such municipality, and acting through its local legislative body, is hereby authorized and empowered to adopt and amend local laws, ordinances or resolutions to establish and operate advanced life support first responder services or municipal ambulance services within the municipality, upon meeting or exceeding all standards set by the department for appropriate training, staffing and equipment, and upon filing with the New York state emergency medical services council, a written request for such authorization. Upon such filing, such municipal advanced life support first responder service or municipal ambulance service shall be deemed to have satisfied any and all requirements for determination of public need for the establishment of additional emergency medical services pursuant to this article for a period of two years following the date of such filing. Nothing in this article shall be deemed to exclude the municipal advanced life support first responder service or municipal ambulance service authorized to be established and operated pursuant to this article from complying with any other requirement or provision of this article or any other applicable provision of law.

(b) In the case of an application for certification pursuant to this subdivision, for a municipal advanced life support or municipal ambulance service, to serve the area within the municipality, where the proposed service meets or exceeds the appropriate training, staffing and equipment standards, there shall be a strong presumption in favor of approving the application. Notwithstanding any other provision of this article, any city with a population of fourteen thousand seven hundred or sixty-two thousand two hundred thirty-five, according to the two thousand ten federal decennial census, or fire district acting on behalf of any such city, that applies for permanent certification pursuant to this section at the conclusion of the two year period provided in this subdivision, shall not be required to apply to its regional emergency medical services council or the state emergency medical services council for a determination of need, and the application shall be submitted to

and approved by the commissioner unless the commissioner finds that the municipal advanced life support first responder service or municipal ambulance service has failed to meet the appropriate training, staffing and equipment standards.

§ 3009. Continuation of existing services. 1. Notwithstanding the provisions of sections three thousand four and three thousand five of this article, if any ambulance service or a predecessor in interest was in bona fide operation as an ambulance service on April first, nineteen hundred seventy-five, within the territory for which application for an ambulance service certificate or voluntary ambulance service statement of registration is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate or statement of registration without requiring proof that there is a public need for such ambulance service and without further proceedings, provided application for such certificate or statement of registration is submitted to the department in accordance with this article prior to September first, nineteen hundred seventy-five. Pending the determination of any such application the continuance of such operation shall be lawful. In all other cases the application shall be decided in accordance with the procedures provided for in section three thousand four or three thousand five of this article and such application shall be approved or denied accordingly. An application pursuant to this section shall be deemed filed with the department upon being mailed to the department by registered or certified mail.

2. Notwithstanding the provisions of subdivision six of section three thousand five of this article, if any advanced life support first response service or a predecessor in interest was in bona fide operation as an advanced life support first response service at the intermediate, critical care, or paramedic level on January first, nineteen hundred ninety-three, within the territory for which application for a certificate is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate without requiring that there is a public need for such service and without further proceedings, provided application for such certificate

or statement of registration is submitted to the department in accordance with this article prior to January first, nineteen hundred ninety-eight. Notwithstanding the provisions of subdivision six of section three thousand five of this article, if any advanced life support first response service or a predecessor in interest was in bona fide operation as an advanced life support first response service at the emt-defibrillation level on July first, nineteen hundred ninety-three, within the territory for which application for a certificate is made pursuant to any provisions of this article, and has so operated since that time, the department shall issue such certificate without requiring that there is a public need for such service and without further proceedings, provided application for such certificate or statement of registration is submitted to the department in accordance with this article prior to January first, nineteen hundred ninety-four. Pending the determination of any such application, the continuance of such operation shall be lawful. In all other cases the application shall be decided in accordance with the procedures provided in section three thousand five of this article and such application shall be approved or denied accordingly. An application pursuant to this section shall be deemed filed with the department upon being mailed to the department by certified or registered mail.

§ 3010. Area of operation; transfers. 1. Every ambulance service certificate or statement of registration issued under this article shall specify the primary territory within which the ambulance service shall be permitted to operate. An ambulance service shall receive patients only within the primary territory specified on its ambulance service certificate or statement of registration, except: (a) when receiving a patient which it initially transported to a facility or location outside its primary territory; (b) as required for the fulfillment of a mutual aid agreement authorized by the regional council; (c) upon express approval of the department and the appropriate regional emergency medical services council for a maximum of sixty days if necessary to meet an emergency need; provided that in order to continue such operation beyond the sixty day maximum period necessary to meet an emergency need, the ambulance service must satisfy the requirements of

this article, regarding determination of public need and specification of the primary territory on the ambulance service certificate or statement of registration; or (d) an ambulance service or advanced life support first response service organization formed to serve the need for the provision of emergency medical services in accordance with the religious convictions of a religious denomination may serve such needs in an area adjacent to such primary territory and, while responding to a call for such service, the needs of other residents of such area at the emergency scene. Any ambulance service seeking to operate in more than one region shall make application to each appropriate regional council. Whenever an application is made simultaneously to more than one regional council, the applications submitted to the regional councils shall be identical, or copies of each application shall be submitted to all the regional councils involved.

2. No ambulance service certificate shall be transferable unless the regional council and the department reviews and approves the transfer as follows:

a. Any change in the individual who is the sole proprietor of an ambulance service shall only be approved upon a determination that the proposed new operator is competent and fit to operate the service.

b. Any change in a partnership which is the owner of an ambulance service shall be approved based upon a determination that the new partner or partners are competent and fit to operate the service. The remaining partners shall not be subject to a character and fitness review.

c. Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the owner of an ambulance service, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of ten percent or more of the stock or voting rights thereunder by any person, shall be approved based upon a determination that the new stockholder or stockholder proposing to obtain ten percent or more of the stock or

voting rights thereunder of such corporation is competent and fit to operate the service. The remaining stockholders shall not be subject to a character and fitness review.

d. Any transfer of all or substantially all of the assets of a corporation which owns or operates a certified ambulance service shall be approved based upon a determination that the individual, partnership, or corporation proposing to obtain all or substantially all of the assets of the corporation is competent and fit to operate the service.

e. Any transfer affected in the absence of the review and approval required by this section shall be null and void and the certificate of such ambulance service shall be subject to revocation or suspension.

3. Nothing contained in this section shall be construed to prohibit any voluntary ambulance service authorized by its governing authority to do so from transporting any sick or injured resident of its primary territory from any general hospital or other health care facility licensed by the department, whether or not such general hospital or health care facility is within the service's primary territory, to any other general hospital or health care facility licensed by the department for further care, or to such resident's home. Nothing contained in this section shall be construed to prohibit any proprietary ambulance service authorized by its governing body to do so from transporting any sick or injured patient from any general hospital or other health care facility licensed by the department whether or not such general hospital or health care facility is within the service's primary territory, to any other general hospital or health care facility licensed by the department within the service's primary territory for further care, or to such patient's home, if such patient's home is within its primary territory. Any ambulance service owned by or under contract to a general hospital licensed by the department may transport any specialty patient from any other general hospital or health care facility licensed by the department to the hospital owning such ambulance service, or with which it has a contract. Categories of specialty patients shall be defined by rule by the state emergency medical services council, subject to the approval of the commissioner.

4. No ambulance service certificate of an ambulance service which has discontinued operations for a continuous period in excess of thirty days shall be transferable without the approval of the appropriate regional council.

§ 3011. Powers and duties of the department and the commissioner. 1.

The department may inquire into the operation of ambulance services and advanced life support first response services and conduct periodic inspections of facilities, communication services, vehicles, methods, procedures, materials, staff and equipment. It may also evaluate data received from ambulance services and advanced life support first response services.

2. The department may require ambulance services and advanced life support first response services to submit periodic reports of calls received, services performed and such other information as may be necessary to carry out the provisions of this article.

3. The commissioner, with the advice and consent of the state council, shall designate not more than eighteen geographic areas within the state wherein a regional emergency medical services council shall be established. In making the determination of a geographic area, the commissioner shall take into consideration the presence of ambulance services, hospital facilities, existing emergency medical services committees, trained health personnel, health planning agencies and communication and transportation facilities; and shall establish separate regional emergency medical services councils for the counties of Nassau and Westchester. The commissioner shall promote and encourage the establishment of a regional emergency medical services council in each of said designated areas.

3-a. Notwithstanding any inconsistent provision of this article:

a. The creation of any regional council or emergency medical services program agency on or after January first, two thousand shall not

diminish any then existing funding appropriated after the effective date of this subdivision to regional councils or emergency medical services program agencies;

b. Subject to the provisions of paragraph c of this subdivision, funding for regional councils and emergency medical services program agencies existing on or after January first, two thousand shall be increased in proportion to any funding appropriated therefor by the department and in such proportion as determined by the department;

c. Funding for any regional council or emergency medical services program agency created on or after January first, two thousand shall be in addition to any funds appropriated on the effective date of this subdivision for regional councils or emergency medical services program agencies existing on January first, two thousand. Funding for any regional council or emergency medical services program agency created after January first, two thousand shall be in an amount at least equal to the minimum funding level appropriated to regional councils or emergency medical services program agencies existing on such date, or in an amount equal to the proportion that such new regional council or emergency medical services program agency represented on the basis of population in its former regional council or emergency medical services program agency, whichever is larger.

4. The commissioner may propose rules and regulations and amendments thereto for consideration by the state council. The commissioner shall establish a schedule of certification fees for ambulance services and advanced life support first response services other than voluntary ambulance services and voluntary advanced life support first response services.

5. For the purpose of promoting the public health, safety and welfare the commissioner is hereby authorized and empowered to contract with voluntary ambulance services and municipal ambulance services, or with the fire commissioners of fire districts operating voluntary ambulance services, upon such terms and conditions as he shall deem appropriate and within amounts made available therefor, for reimbursement of the

necessary and incidental costs incurred by such ambulance services in order to effectuate the provisions of this article.

6. The commissioner is hereby authorized, for the purposes of effectuating the provisions of this article in the development of a statewide emergency medical service system, to contract with any ambulance service or with the fire commissioners of fire districts operating certified voluntary ambulance services for the use of necessary equipment upon such terms and conditions as the commissioner shall deem appropriate.

7. The commissioner may recommend to the state council minimum qualifications for certified first responders (which shall not exceed fifty-one hours), emergency medical technicians and advanced emergency medical technicians in all phases of emergency medical technology including but not limited to, communications, first aid, equipment, maintenance, emergency techniques and procedures, patient management and knowledge of procedures and equipment for emergency medical care.

8. The commissioner shall provide every certified ambulance service and advanced life support first response service with an official insignia which may be attached to every vehicle owned or operated by a certified ambulance service or advanced life support first response service.

9. The department shall provide the state council with such assistance as the council may request in order to carry out its responsibilities as set forth in subdivision two-a of section three thousand two of this article.

10. The commissioner is hereby authorized and empowered to extend the certification for emergency medical technicians, advanced emergency medical technicians or certified first responders who have been ordered to active military duty, other than for training, on or after the eleventh day of September, two thousand one and whose certification will expire during their military duty or within the six months immediately following separation from military service. The extended certification

shall be for the period of military duty and for twelve months after they have been released from active military duty.

11. The commissioner, with the advice and consent of the state council, shall promulgate rules and regulations necessary to ensure compliance with the provisions of subdivision two of section sixty-seven hundred thirteen of the education law.

§ 3012. Enforcement. 1. Any ambulance service or advanced life support first response service certificate issued pursuant to section three thousand five of this article may be revoked, suspended, limited or annulled by the department upon proof that the operator or certificate holder or one or more enrolled members or one or more persons in his employ:

(a) has been guilty of misrepresentation in obtaining the certificate or in the operation of the ambulance service or advanced life support first response service; or

(b) has not been competent in the operation of the service or has shown inability to provide adequate ambulance services or advanced life support first response service; or

(c) has failed to pay the biennial certification fee as required except in the case of any voluntary ambulance service or voluntary advanced life support first response service; or

(d) has failed to file any report required by the provisions of this article or the rules and regulations promulgated thereunder; or

(e) has violated or aided and abetted in the violation of any provision of this article, the rules and regulations promulgated or continued thereunder, or the state sanitary code; or

(f) had discontinued operations for a period in excess of one month; or

(g) a voluntary ambulance service or voluntary advanced life support first response service has failed to meet the minimum staffing standard and has not been issued an exemption, except that such certificate shall not be suspended or revoked unless the commissioner finds that an adequate alternative service exists. The commissioner shall consider the recommendation of the regional emergency medical services council in

making a finding; or

(h) an ambulance service operating for profit has failed to meet the minimum staffing standard; or

(i) has been convicted of a crime or pleaded nolo contendere to a felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or sale of drugs, unless the commissioner finds that such conviction does not demonstrate a present risk or danger to patients or the public; or

(j) is or was subject to a state or federal administrative order relating to fraud or embezzlement, unless the commissioner finds that such order does not demonstrate a present risk or danger to patients or the public.

2. Proceedings under this section may be initiated by any person, corporation, association, or public officer, or by the department by the filing of written charges with the department. Whenever the department seeks revocation or suspension of a certificate of an ambulance service or an advanced life support first response service, a copy of the charges shall be referred to the appropriate regional council for review and recommendation to the department prior to a hearing. Such recommendation shall include a determination as to whether the public need would be served by a revocation, suspension, annulment or limitation. If there is no appropriate regional council established, the state council shall make such determination and present to the department its recommendations.

3. No certificate shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended without a hearing and without the approval of the appropriate regional council or state council for a period not in excess of thirty days upon notice to the certificate holder following a finding by the department that the public health, safety or welfare is in imminent danger.

4. The commissioner shall fix a time and place for the hearing. A copy of the charges and the recommendations of the appropriate regional council or state council together with the notice of the time and place of the hearing, shall be mailed to the certificate holder by registered

or certified mail, at the address specified on the certificate, at least fifteen days before the date fixed for the hearing. The appropriate regional council may be a party to such hearing. The certificate holder may file with the department, not less than five days prior to the hearing, a written answer to the charges.

§ 3013. Immunity from liability. 1. Notwithstanding any inconsistent provision of any general, special or local law, a voluntary ambulance service or voluntary advanced life support first response service described in section three thousand one of this article and any member thereof who is a certified first responder, an emergency medical technician, an advanced emergency medical technician or a person acting under the direction of an emergency medical technician or advanced emergency medical technician and who voluntarily and without the expectation of monetary compensation renders medical assistance in an emergency to a person who is unconscious, ill or injured shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such medical assistance in an emergency unless it is established that such injuries were or such death was caused by gross negligence on the part of such certified first responder, emergency medical technician or advanced emergency medical technician or person acting under the direction of an emergency medical technician or advanced emergency medical technician.

2. Nothing in this section shall be deemed to relieve any such voluntary ambulance service or voluntary advanced life support first response service from liability for damages or injuries or death caused by an act or omission on the part of any person other than a certified first responder, an emergency medical technician, advanced emergency medical technician or person acting under the direction of an emergency medical technician or advanced emergency medical technician acting in behalf of the voluntary ambulance service or voluntary advanced life support first response service.

3. Nothing in this section shall be deemed to relieve or alter the liability of any such voluntary ambulance service or members for damages or injuries or death arising out of the operation of motor vehicles.

4. A certified first responder, emergency medical technician or advanced emergency medical technician, whether or not he or she is acting on behalf of an ambulance service or advanced life support first response service, who voluntarily and without the expectation of monetary compensation renders medical assistance in an emergency to a person who is unconscious, ill or injured shall not be liable for damages alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such medical assistance in an emergency unless it is established that such injuries were or such death was caused by gross negligence on the part of such certified first responder, emergency medical technician or advanced emergency medical technician.

5. Notwithstanding any inconsistent provision of any general, special or local law, any physician who voluntarily and without the expectation of monetary compensation provides indirect medical control, as defined in paragraph (b) of subdivision fifteen of section three thousand one of this article, to a voluntary ambulance service or voluntary advanced life support first response service described in section three thousand one of this article shall not be liable for damages for injuries or death alleged to have been sustained by any person as a result of such medical direction unless it is established that such injuries or death were caused by gross negligence on the part of such physician.

6. The availability of an award or other benefit under article eleven-AA or article eleven-AAA of the general municipal law shall not be deemed monetary compensation for the purposes of this section.

§ 3014. Construction. Notwithstanding any inconsistent provision of any general, special or local law, the provisions of this article shall be deemed to apply to the city of New York.

§ 3015. Separability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this article directly involved in the controversy in which the judgment shall have been rendered.

§ 3016. Continuance of rules and regulations. All rules and regulations heretofore adopted by the commissioner pertaining to all ambulance services shall continue in full force and effect as rules and regulations until duly modified or superseded by rules and regulations hereafter adopted and enacted by the state council pursuant to section three thousand two of this article.

§ 3017. Emergency medical service, Suffolk county. 1. No ambulance service or advanced life support first response service shall respond to any call or request for emergency medical services within a town, village or fire district in Suffolk county that currently provides ambulance service or advanced life support services first response service, if the municipality has designated one or more ambulance services or advanced life support first response services to respond to such calls unless:

- (a) the service is so designated;
- (b) the response is in accordance with a mutual aid plan approved by the appropriate regional emergency medical service council;
- (c) the response is to a verbal mutual aid request from a designated service;
- (d) the service was specifically requested to respond by the patient or someone acting on behalf of that patient; or
- (e) the response site is a hospital licensed under article twenty-eight of this chapter for a transfer to another such facility.

2. Every ambulance service or advanced life support first response service shall disclose as part of any solicitation or advertisement in Suffolk county that there is a fee for services rendered, if in fact there is a fee charged for the performance of such service.

3. Every ambulance service or advanced life support first response service that operates in Suffolk county and has vehicles which travel through communities with designated ambulance service or advanced life support first response service shall require its drivers and emergency medical technicians:

(a) to immediately notify a central alarm or other publicly operated dispatch entity, or a person designated under section two hundred nine-b of the general municipal law to receive calls for emergency services for the purpose of dispatching emergency medical services whenever an emergency is found in a public place;

(b) to evaluate the need to transport any patient found in extremis to a hospital; and

(c) to comply with appropriate instructions from the dispatch entity. The dispatch entity, when appropriate, may instruct the service to transport any patient to an appropriate hospital.

*** § 3018. Community-based paramedicine demonstration program.** 1. The department shall establish a community paramedicine demonstration program to evaluate the role of emergency medical services personnel in the delivery of health care services in the community in non-emergent settings.

2. For purposes of this section, "emergency medical services personnel" shall mean an emergency medical technician, or an advanced emergency medical technician as defined in this article.

3. This program shall authorize mobile integrated and community paramedicine programs presently operating and approved by the department as of May eleventh, two thousand twenty-three, under the authority of Executive Order Number 4 of two thousand twenty-one, entitled "Declaring a Statewide Disaster Emergency Due to Healthcare staffing shortages in

the State of New York" to continue in the same manner and capacity as currently approved for a period of four years following the effective date of this section.

4. Such program shall include but not be limited to:

(a) authorizing emergency medical services personnel to provide services within their scope of practice beyond settings currently authorized.

(b) authorizing emergency medical service personnel to provide community paramedicine, use alternative destinations, telemedicine to facilitate treatment of persons in place, and such other services as may be approved by the commissioner.

(c) authorizing emergency medical services personnel providing community paramedicine services, with prior approval of the department, to administer vaccinations against influenza and COVID-19 pursuant to non-patient specific orders and under the medical direction of a licensed physician.

(d) nothing in this section shall be deemed to allow a person to provide any service for which a license, registration, certification or other authorization under title eight of the education law is required and which the person does not possess, provided that any service being excluded pursuant to this paragraph shall not include a service that is within the scope of practice for the respective emergency medical services personnel.

5. Upon the effective date of this section, the department shall convene a stakeholder advisory panel including patient representatives, health care facilities operating or utilizing community paramedicine programs, emergency medical services providers and labor organizations representing emergency medical services personnel, and labor organizations representing nursing and other healthcare professional titles affected by the demonstration program flexibilities to advise the department to make recommendations on regulations and guidance that will:

(a) evaluate patient safety and standards of care for community paramedicine programs participating in the demonstration program;

(b) establish criteria setting forth permitted tasks that can be

performed by each category of emergency medical services personnel;

(c) establish minimum training and competencies required for emergency medical services personnel to provide patient care services; and

(d) work with the department to issue such regulations and guidelines within ninety days following the assembly of the advisory panel.

6. The department shall submit a report on the demonstration program on an annual basis to the speaker of the assembly, the temporary president of the senate, the chairs of the assembly and senate health committees, and the governor.

* NB Repealed June 22, 2027

§ 3019. Department review of comprehensive county emergency medical system plans. 1. The department, in consultation with the state emergency medical services council, the regional emergency medical services councils, or any other group the department deems necessary, may make available a model comprehensive county emergency medical system plan format to help provide guidance to counties to consider when developing their comprehensive county emergency medical system plan required pursuant to section one hundred twenty-two-b of the general municipal law. Such model plan shall be made publicly available on the department's website and outline the components of the plan that the department deems most effective to facilitate their timely review and meaningful feedback on each county's plan.

2. Upon receipt of a county's comprehensive county emergency medical system plan submitted to the department pursuant to section one hundred twenty-two-b of the general municipal law, the department shall review such plan and provide written feedback and any recommendations, within sixty days of such plan's submission, for review by the county.

§ 3020. Recruitment and retention. 1. The commissioner shall establish and fund within amounts appropriated, a public service campaign to recruit additional personnel into the emergency medical system fields.

2. The commissioner shall establish and fund within amounts appropriated an emergency medical system mental health and wellness program that provides resources to emergency medical service practitioners to retain personnel in the emergency medical system fields.

§ 3030. Advanced life support services. Advanced life support services provided by an advanced emergency medical technician, shall be (1) provided under the direction of qualified medical and health personnel utilizing patient information and data transmitted by voice or telemetry, (2) limited to the category or categories in which the advanced emergency medical technician is certified pursuant to this article, and (3) recorded for each patient, on an individual treatment-management record.

§ 3031. Advanced life support system. Advanced life support system must (1) be under the overall supervision and direction of a qualified physician with respect to the advanced life support services provided, (2) be staffed by qualified medical and health personnel, (3) utilize advanced emergency medical technicians whose certification is appropriate to the advanced life support services provided, (4) utilize advanced support mobile units appropriate to the advanced life support services provided, (5) maintain a treatment-management record for each patient receiving advanced life support services, and (6) be integrated with a hospital emergency, intensive care, coronary care or other appropriate service.

§ 3032. State emergency medical services task force. 1. The department shall develop a state emergency medical services (EMS) task force, operated by the department, that may coordinate and operate resources that are needed around the state in situations including but not limited to a disaster, specialized response, or community need.

2. The state EMS task force shall be made up of non-government and

government agencies, that are licensed to provide emergency medical services in the state including but not limited to commercial agencies, nonprofits, fire departments and third services.

3. The department shall allocate funds to effectuate the delivery of the state EMS task force that shall allow for contracting with licensed emergency medical services agencies, the purchase of specialized response equipment, staff to carry out the daily functions of the state EMS task force either directly or by contract and other functions as determined by the department.

4. The state emergency medical services council shall make recommendations to the department to effectuate the development and delivery of care by the state EMS task force.

5. The state EMS task force shall have the authority to operate throughout New York state.

§ 3033. Rules and regulations. The commissioner, upon approval of the state emergency medical services council, may promulgate rules and regulations to effectuate the purposes of this article, provided, however, that sections three thousand thirty and three thousand thirty-one of this article shall be subject to the provisions of section three thousand thirty-four of this article.

§ 3034. Rules and regulations. The state council, with the approval of the commissioner, shall promulgate rules and regulations to effectuate the purposes of sections three thousand thirty and three thousand thirty-one of this article.

ARTICLE 30-A

EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING ACT OF NINETEEN HUNDRED EIGHTY-SIX

Section 3050. Short title.

3051. Declaration of purpose.

3052. Establishment of a training program for emergency medical services personnel.

3053. Reporting.

3054. Emergency situations involving individuals with autism spectrum disorder and other developmental disabilities.

§ 3050. Short title. This article shall be known and may be cited as the "emergency medical services personnel training act of nineteen hundred eighty-six".

§ 3051. Declaration of purpose. Emergency medical services provided to those suffering from sudden illness or injury have potential to reduce the incidence of disability and death and are therefore, invaluable. A training program of high quality is the key to assuring that emergency medical services personnel have the knowledge and skills to care for acutely ill and injured patients in a manner which will prevent further illness and injury. There is therefore a need to provide flexible, diverse and high quality training opportunities which are reasonably available, particularly to volunteers who devote considerable time, effort, and often personal resources, to improve or retain their knowledge and skills. The state has a responsibility to support and further the work of those who provide emergency medical care by providing needed instructional resources.

The purpose of this article is to expand and improve training opportunities for emergency medical service personnel, thereby benefiting all the residents of New York state who rely on the services of these personnel.

§ 3052. Establishment of a training program for emergency medical services personnel. 1. There is hereby established a training program for emergency medical services personnel including, but not limited to, first responders, emergency medical technicians, advanced emergency

medical technicians and emergency vehicle operators.

2. The commissioner shall provide state aid within the amount appropriated to entities such as local governments, regional emergency medical services councils, and voluntary agencies and organizations to conduct training courses for emergency medical services personnel and to conduct practical examinations for certification of such personnel. The commissioner shall establish a schedule for determining the amount of state aid provided pursuant to this section.

a. Such schedule may include varying rates for distinct geographic areas of the state and for various course sizes, giving special consideration to areas with the most need for additional emergency medical technicians. In determining the need for additional emergency medical technicians, the commissioner shall use measurements such as the average number of emergency medical technicians per ambulance service, the ratio of emergency medical technicians per square mile, the average number of calls per service and the percentage of calls to which an emergency medical technician has responded, provided such data is available to the commissioner.

b. Such schedule shall provide sufficient reimbursement to permit sponsors to offer basic emergency medical technician courses which adhere to curricula approved by the New York state emergency medical services council and the commissioner without the need to charge tuition to participants.

3. Upon request, the commissioner shall provide management advice and technical assistance to regional emergency medical services councils, county emergency medical services coordinators, and course sponsors and instructors to stimulate the improvement of training courses and the provision of courses in a manner which encourages participation. Such advice and technical assistance may relate to, but need not be limited to the location, scheduling and structure of courses.

4. The department is authorized, either directly or through contractual arrangement, to develop and distribute training materials

for use by course instructors and sponsors, to recruit additional instructors and sponsors and to provide training courses for instructors.

5. The commissioner shall conduct a public service campaign to recruit additional volunteers to join ambulance services targeted to areas in need for additional emergency medical technicians.

§ 3053. Reporting. Advanced life support first response services and ambulance services registered or certified pursuant to article thirty of this chapter shall submit detailed individual call reports on a form to be provided by the department, or may submit data electronically in a format approved by the department. The state emergency medical services council, with the approval of the commissioner, may adopt rules and regulations permitting or requiring ambulance services whose volume exceeds twenty thousand calls per year to submit call report data electronically. Such rules shall define the data elements to be submitted, and may include requirements that assure availability of data to the regional emergency medical advisory committee.

§ 3054. Emergency situations involving individuals with autism spectrum disorder and other developmental disabilities. In coordination with the commissioner of the office for people with developmental disabilities, the commissioner shall provide the training program relating to handling emergency situations involving individuals with autism spectrum disorder and other developmental disabilities and associated training materials pursuant to section 13.43 of the mental hygiene law to all emergency medical services personnel including, but not limited to, first responders, emergency medical technicians, advanced emergency medical technicians and emergency vehicle operators.

ARTICLE 30-B

EMERGENCY MEDICAL, TRAUMA AND DISASTER CARE

Section 3060. Short title.

- 3061. Declaration of purpose.
- 3062. Definitions.
- 3063. State emergency medical advisory committee.
- 3064. State trauma advisory committee.
- 3065. Regional trauma advisory committees.
- 3066. Powers and duties of the department.

§ 3060. Short title. This article shall be known and may be cited as the "emergency medical, trauma care, and disaster preparedness act".

§ 3061. Declaration of purpose. Trauma is the leading cause of death and disability during the first four decades of life. In the aftermath of the events of September eleventh, two thousand one, the medical response to natural and man-made disasters is also recognized as a public concern of the highest order. The furnishing of emergency medical, trauma, and disaster care is therefore a matter of vital concern affecting the public health, safety and welfare. Emergency medical, trauma, and disaster care, the planning and coordination of such care between prehospital and inhospital personnel and collaborating public health, safety, and welfare officials, the quality management and review of such care, and the development and maintenance of a statewide system for interfacility transfer, including but not limited to aeromedical transport, of critically ill or injured patients between general hospitals and other health care facilities, are essential public health services. It is the purpose of this article to promote the public health, safety and welfare by providing for development and maintenance of systems for emergency medical, trauma, and disaster care, and for expeditious transfer of patients in need of such care to facilities appropriately staffed and equipped to provide this care in a timely and effective manner.

§ 3062. Definitions. As used in this article:

1. "Emergency medical care" means the initial management, treatment,

and transfer of suddenly ill or injured patients.

2. "Trauma care" means health care provided to patients at high risk of death or disability from multiple and severe injuries.

3. "Emergency patient" means any patient making an unscheduled visit to a hospital emergency facility for emergency medical care.

4. "Emergency department" means a hospital department consisting of staff, facilities, and resources to provide emergency medical care for large numbers of emergency patients.

5. "Emergency service" means a hospital department consisting of staff, facilities, and resources to provide emergency medical care for small numbers of emergency patients.

6. "Emergency physician" means a staff physician providing emergency medical care in an emergency department or emergency service.

7. "Emergency nurse" means a staff nurse providing nursing services in an emergency department or emergency service.

8. "Trauma patient" means a patient at high risk of death or disability from multiple and severe injuries.

9. "Trauma system" means an organized health care system to provide trauma care in, or en route to, from, or between general hospitals or other health care facilities.

10. "Trauma center" means a facility capable of providing definitive trauma care.

11. "Trauma station" means a facility capable of providing sustentative trauma care followed by expeditious transfer to a trauma center.

12. "Trauma surgeon" means a staff surgeon providing trauma care in a

trauma center or trauma station or during aeromedical transport.

13. "Trauma nurse" means a staff nurse providing nursing services in a trauma center or trauma station, or during aeromedical transport.

14. "Prehospital transport" means emergency ambulance transport from the scene of a sudden illness or injury requiring emergency medical care or trauma care to a general hospital or other health care facility, conducted in accordance with article thirty of this chapter.

15. "Interfacility transfer" means emergency ambulance transport from, to, or between general hospitals or other health care facilities, conducted in accordance with article thirty of this chapter.

16. "Aeromedical transport" means prehospital transport or interfacility transfer conducted in rotary wing or fixed wing aircraft.

17. "Transport system" means an organized health care and transportation system to provide prehospital transport and interfacility transfer to critically ill or injured patients.

18. "Critically ill or injured" means at high risk of dying from illnesses or injuries.

19. "Disaster preparedness" means the state of readiness necessary to respond to natural or man-made disasters, including but not limited to biologic, nuclear, incendiary, chemical, and explosive disasters.

20. "Interoperability" means the capacity of all emergency medical, trauma care, and disaster preparedness response systems to collaborate and communicate during an emergency, trauma, or disaster response.

21. "State hospital review and planning council" means the state hospital review and planning council established by section twenty-nine hundred four of this chapter.

22. "State emergency medical services council" means the state

emergency medical services council established by section three thousand two of this chapter.

23. "State emergency medical advisory committee" means the state emergency medical advisory committee established by section three thousand two-a of this chapter.

24. "State trauma advisory committee" means the state trauma advisory committee continued by this article.

25. "Regional emergency medical services council" means a regional emergency medical services council established by section three thousand three of this chapter.

26. "Regional emergency medical advisory committee" means a regional emergency medical advisory committee established by section three thousand four-a of this chapter.

27. "Regional trauma advisory committee" means a regional trauma advisory committee continued or established by this article.

28. "Regional trauma program agency" means an entity that may be contracted by the department to assist the department in providing the ways and means necessary for a regional trauma advisory committee to perform the duties specified under this article.

§ 3063. State emergency medical advisory committee. 1. The state emergency medical advisory committee, in addition to the powers and responsibilities described in section three thousand two-a of this chapter, shall advise the department and the commissioner regarding emergency medical care, and assist the department and the commissioner in the development, periodic revision, and application of appropriateness review standards and quality improvement guidelines for emergency medical care, emergency departments and emergency services, under articles twenty-eight and thirty of this chapter.

2. The commissioner shall designate an officer or employee of the department to assist the state emergency medical advisory committee in the performance of its duties under this section.

§ 3064. State trauma advisory committee. 1. There is hereby continued in the department the state trauma advisory committee. It shall consist of trauma surgeons, trauma nurses, emergency physicians, emergency nurses, and other emergency medical and trauma care professionals appointed by the commissioner. It shall be representative of each geographic area of the state and those medical and nursing specialties and subspecialties regularly involved in trauma care. It shall advise the department and the commissioner regarding trauma and disaster care within the state, and assist the department and the commissioner in the coordination of trauma and disaster care, including but not limited to, the development, periodic revision, and application of statewide appropriateness review standards, quality improvement guidelines for trauma and disaster care, trauma systems, trauma centers and trauma stations, in a manner consistent with the intent and provisions of sections twenty-eight hundred five-j and three thousand two-a of this chapter, and similar advisory guidelines for trauma and disaster care with the consent of the commissioner, which shall not have the force and effect of law unless adopted as rules and regulations by the state hospital review and planning council, subject to approval by the commissioner. The commissioner shall appoint a physician to chair the committee.

2. The state trauma advisory committee shall continue to meet as frequently as its business may require. The members of the state trauma advisory committee shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

3. The commissioner shall designate an officer or employee of the department to assist the state trauma advisory committee in the performance of its duties under this section.

4. In no event shall any member, officer, or employee of the state trauma advisory committee be liable for damages in any civil action for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the state trauma advisory committee if he or she shall have acted in good faith, with reasonable care.

§ 3065. Regional trauma advisory committees. 1. There are hereby continued or established in the department regional trauma advisory committees in each geographic area of the state. They shall consist of trauma surgeons, trauma nurses, emergency physicians, emergency nurses, and other emergency and trauma care professionals from trauma centers, emergency departments, and emergency services designated by the department within each region. They shall be representative of the communities and health care facilities within the region and those medical and nursing specialties and subspecialties regularly involved in trauma care. They shall advise the state trauma advisory committee, the department, and the commissioner regarding trauma and disaster care within each region, and assist the state trauma advisory committee, the department, and the commissioner with the coordination of trauma and disaster care within each region, including, but not limited to, the implementation of statewide quality improvement guidelines for trauma and disaster care, trauma systems, trauma centers, and trauma stations within each region, in a manner consistent with the intent and provisions of sections twenty-eight hundred five-j and three thousand four-a of this chapter. The state trauma advisory committee shall authorize the bylaws of each regional trauma advisory committee, subject to approval by the commissioner.

2. The regional trauma advisory committees shall continue to meet as frequently as their business may require. The members of the regional trauma advisory committees shall receive no compensation for their services as members.

3. The department shall determine the ways and means necessary to assist the regional trauma advisory committees in performing the duties

specified under this section, and may contract with regional trauma program agencies to provide such assistance.

4. In no event shall any member, officer, or employee of the state trauma advisory committee be liable for damages in any civil action for any act done, failure to act, or statement of opinion made, while discharging his or her duties as a member, officer, or employee of the regional trauma advisory committee if he or she shall have acted in good faith, with reasonable care.

§ 3066. Powers and duties of the department. 1. The department shall continue facilitation, development, and periodic revision of appropriateness review standards for emergency medical and trauma care, including appropriateness review standards for emergency departments and services and trauma centers and stations under article twenty-eight of this chapter, by the state emergency medical advisory committee or the state trauma advisory committee, as appropriate, for adoption by the state hospital review and planning council, subject to approval by the commissioner.

2. The department shall continue the categorization of general hospitals and other health care facilities for emergency medical care and trauma care under article twenty-eight of this chapter, and the designation of emergency facilities in general hospitals and other health care facilities, as emergency departments or emergency services appropriate for emergency medical care and general hospitals and other health care facilities as trauma centers or trauma stations appropriate for trauma care, based upon such categorization, after appropriate on-site verification.

3. The department shall continue development and maintenance of statewide and regional quality improvement programs for trauma and disaster care in a manner consistent with the intent and provisions of sections twenty-eight hundred five-j, three thousand two-a and three thousand four-a of this chapter, incorporating quality improvement programs for all components of the trauma system involved in trauma care

including, but not limited to fully integrated statewide and regionwide trauma registries, and the ways and means to support them.

4. The department shall develop and periodically revise a comprehensive emergency medical and trauma care plan with the advice of the state emergency medical services council, the state emergency medical advisory committee and the state trauma advisory committee, incorporating injury control programs and ongoing quality assurance measures for all components of the trauma system involved in trauma care.

5. The department shall develop and periodically revise medical and operational guidelines for a fully integrated statewide transport system, with the advice of the state emergency medical services council, the state emergency medical advisory committee and the state trauma advisory committee subject to approval by the commissioner, and shall develop and maintain a statewide system for coordination of interfacility transfers.

6. The department shall develop and periodically revise medical and operational guidelines for a fully integrated statewide medical disaster preparedness response, with the advice of the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee, subject to approval by the commissioner, and shall develop and maintain a statewide system for coordination of medical disaster preparedness and trauma system planning.

7. The department shall facilitate the coordination and implementation of regional emergency medical system, trauma system, and medical disaster preparedness response plans, with the advice of the regional emergency medical services councils, the regional emergency medical advisory committees, and the regional trauma advisory committees, and shall promote full interoperability of all response and communications systems.

ARTICLE 30-C

EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section 3070. Short title.

3071. Declaration of purpose.

3072. Description.

3073. Definitions.

3074. State emergency medical services for children advisory committee.

3075. Powers and duties of the department.

§ 3070. Short title. This act shall be known and may be cited as the "emergency medical services for children act".

§ 3071. Declaration of purpose. Sudden illness and injury in children within the state of New York are responsible for five percent of all ambulance calls in children under ten years of age, ten percent of all ambulance calls in children under eighteen years of age, twenty-five percent of emergency department visits in urban areas, and forty percent of emergency department visits in rural areas. More than fifty percent of all such emergencies are caused by traumatic injuries, which alone are responsible for more than half of all childhood deaths within the state of New York regardless of cause. The provision of timely and effective emergency medical services for children, including pediatric emergency medical, trauma, and disaster care, are therefore public health priorities of the highest order. It is the purpose and intent of this article to ensure that such services are immediately available to all children within the state of New York.

§ 3072. Description. Emergency medical services for children is a system for the immediate recognition and management of sudden illness and injury in children that embraces the continuum of pediatric emergency medical, trauma, and disaster care, from prevention through rehabilitation, and addresses emergency medical dispatch, prehospital emergency care, in-hospital emergency care, and primary, secondary, and

tertiary health care, in support of pediatric care provided within the child's medical home. It is not separate from, but fully integrated with, the emergency medical services system at all levels of emergency medical services system organization, in the community, in the region, and in the state.

§ 3073. Definitions. As used in this article:

1. "State emergency medical services for children advisory committee" means the state emergency medical services for children advisory committee continued under this article.

2. "State emergency medical services council" means the state emergency medical services council established under article thirty of this chapter.

3. "State emergency medical advisory committee" means the state emergency medical advisory committee established under article thirty of this chapter.

4. "State trauma advisory committee" means the state trauma advisory committee continued under article thirty-B of this chapter.

5. "Pediatric care" means medical care provided to neonates, infants, toddlers, preschoolers, school agers, and adolescents.

6. "Medical home" means an organized system of medical care for an individual patient that embraces all of the patient's potential medical needs, including primary, secondary, and tertiary health care as well as emergency care.

§ 3074. State emergency medical services for children advisory committee. 1. There is hereby continued in the department the state emergency medical services for children advisory committee. It shall consist of child health professionals and child health advocates

representative of all geographic areas of the state and of those occupations regularly involved in the care of children with emergency health care needs. Its members shall include, but not necessarily be limited to, a pediatric emergency medicine physician and nurse, a pediatric critical care physician and nurse, a pediatric surgeon, a pediatric physiatrist, a pediatric primary care physician, an emergency medicine physician, a pediatric emergency medical services physician, a pediatric toxicologist physician, a prehospital care provider, a school nurse, a hospital administrator, the parent of a previously ill or injured child, and the parent of a child with special health care needs, appointed by the commissioner upon recommendation of the appropriate statewide professional or parental organizations for terms of four years, which may be renewed. It shall advise the department, the commissioner, the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee regarding all aspects of emergency medical services for children, including, but not necessarily limited to, pediatric emergency medical, trauma, and disaster care, and the early care of maltreated children and children with special health care needs. The state emergency medical services director, the state emergency medical services medical director, the state emergency medical services for children program director, the state emergency medical services for children program coordinator, the state trauma medical director, the state trauma program manager, the governor's highway traffic safety administrator, and the state emergency medical services for children data manager, shall also serve as nonvoting members ex officio. The commissioner shall appoint a physician to chair the committee.

2. The state emergency medical services for children advisory committee shall meet as frequently as its business may require, but ordinarily no less than quarterly. The members of the state emergency medical services for children advisory committee shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of his or her duties under this section.

3. The commissioner shall designate an officer or employee of the

department to assist the state emergency medical services for children advisory committee in the performance of its duties under this section, to coordinate the activities of the state emergency medical services for children program and to facilitate communication with the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee.

4. In no event shall any member, officer, or employee of the state emergency medical services for children advisory committee be liable for damages in any civil action for any act done, failure to act, or statement or opinion made, while discharging his or her duties as a member, officer, or employee of the state emergency medical services for children advisory committee if he or she shall have acted in good faith, with reasonable care.

§ 3075. Powers and duties of the department. 1. The department shall develop and maintain, with the advice of the state emergency medical services for children advisory committee, the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee, a statewide system for recognition of facilities able to provide sustentative or definitive specialty pediatric emergency medical and trauma care for sudden childhood illness and injury and for preferential transport of suddenly ill or injured children to such facilities, and shall promote the use of such facilities in accordance with written protocols or transfer agreements as appropriate.

2. The department shall develop and maintain, with the advice of the state emergency medical services for children advisory committee, the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee, a statewide system for provision of prehospital medical oversight, including direct and indirect medical control, for pediatric emergencies.

3. The department shall develop, maintain, and offer, with the advice of the state emergency medical services for children advisory committee,

the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee, statewide educational programs for initial and continuing education in pediatric prehospital basic and advanced life support, including child maltreatment recognition and management, consistent with those of national professional organizations concerned with child health and emergency care.

4. The department shall develop, maintain, and adopt, with the advice of the state emergency medical services for children advisory committee, the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee, statewide equipment guidelines for basic and advanced life support of pediatric emergencies, consistent with those of national professional organizations concerned with child health and emergency care.

5. The department shall ensure that all other aspects of emergency medical services for children are also properly integrated with all other emergency medical services, trauma care, and disaster preparedness programs, with the advice of the state emergency medical services for children advisory committee, and shall facilitate timely communication among the state emergency medical services for children advisory committee, the state emergency medical services council, the state emergency medical advisory committee, and the state trauma advisory committee as appropriate.

ARTICLE 31

HUMAN BLOOD AND TRANSFUSION SERVICES

- Title I. General provisions (Sec. 3100).
- II. Regulation of the business of blood donating (Secs. 3120-3122).
- III. Blood donors of the age of eighteen years or over (Secs. 3123-3124).

TITLE I

GENERAL PROVISIONS

Section 3100. Human blood and its derivatives; collection, processing, storage and distribution; general powers of commissioner.

§ 3100. Human blood and its derivatives; collection, processing, storage and distribution; general powers of commissioner. 1. The commissioner is hereby authorized:

(a) to establish, equip, maintain and conduct a suitable program to collect, process, store and distribute human blood, and the various human blood derivatives including special therapeutic and diagnostic serums, which are deemed of value in the treatment of sick and injured persons, and the prevention of certain diseases;

(b) to carry out such educational and research activities as he may deem necessary in connection with said program; and

(c) to establish necessary rules and regulations to effect the purpose of this article.

2. The commissioner may conduct such program solely as a state activity, or in cooperation with such institutions, hospitals or municipal corporations as he may select, on such terms as may be agreed upon.

TITLE II

REGULATION OF THE BUSINESS OF BLOOD DONATING

Section 3120. Blood collection; permit required; procedure.

3121. Council on human blood and transfusion services.

3122. Blood donating; violations; penalties.

§ 3120. Blood collection; permit required; procedure.

No person, firm or corporation shall collect human blood for the purpose of transfusion into another human being unless a permit has been issued pursuant to the provisions of title five of article five of this

chapter.

§ 3121. Council on human blood and transfusion services. 1. There is hereby created in the department a council on human blood and transfusion services, hereinafter known as the "council," to consist of the commissioner and eight other members appointed by the governor, with the advice and consent of the senate, one of whom shall be a representative of the public. The remaining appointive members shall have had experience or training having rendered them knowledgeable in the various aspects of blood banking services, and may include but shall not be limited to, representatives of voluntary and commercial blood banks, representatives of hospitals, and physicians. The governor shall designate one member to serve as chairman.

2. The term of office of each appointive member of the council shall be for three years, provided, however, that of the members first appointed, three shall be appointed for terms which shall expire on December thirty-first, nineteen hundred seventy-four, three for terms which shall expire on December thirty-first, nineteen hundred seventy-five and two shall be appointed for terms which shall expire on December thirty-first, nineteen hundred seventy-six. Vacancies shall be filled by appointment for the unexpired term. The appointive members shall continue in office until the expiration of their terms and until their successors are appointed and have qualified.

3. The council shall meet as frequently as its business may require. The members of the council shall receive no compensation for their services as members of the council, but each of them shall be allowed the necessary and actual expenses which he shall incur in the performance of his duties under this section.

4. The commissioner, upon request of the council, shall designate an officer or employee of the department to act as secretary of the council, and shall assign from time to time such other employees as the council may require.

5. The council shall have power by the affirmative vote of a majority of its members to enact, and from time to time, amend and repeal, rules and regulations establishing minimum standards for the proper collection, processing, fractionation, storage, distribution, and supply of human blood or blood derivatives, for the purpose of transfusions, subject to approval by the commissioner.

§ 3122. Blood donating; violations; penalties. Any violation of sections three thousand one hundred twenty and three thousand one hundred twenty-one, of this chapter, shall constitute a misdemeanor, punishable on conviction by a fine of not exceeding fifty dollars or by imprisonment for not exceeding six months, or both such fine and imprisonment.

TITLE III

BLOOD DONORS OF THE AGE OF EIGHTEEN YEARS OR OVER

Section 3123. Blood donors of the age of seventeen years or over.

3124. Reporting system for hospitals and blood banks.

§ 3123. Blood donors of the age of seventeen years or over. Any person of the age of seventeen years or over shall be eligible to donate blood in any voluntary and noncompensatory blood program without the necessity of obtaining parental permission or authorization.

§ 3124. Reporting system for hospitals and blood banks. All persons, firms and corporations engaged in procuring blood donations shall report annually the following information to the commissioner of health:

- a. The amount of whole blood collected.
- b. The amount fractionated.
- c. When fractionated.

d. How much blood is unused and destroyed.

e. How much blood is converted and what is it converted into.

f. Any other information the commissioner finds necessary to have an accurate picture of what happens to collected blood within the state.

The commissioner shall make such rules and regulations as are necessary to create an accurate and complete reporting system.

ARTICLE 32

LIVE PATHOGENIC MICROORGANISMS OR VIRUSES

Section 3200. Live pathogenic microorganisms or viruses; handling; registration required; exceptions.

3201. Live pathogenic microorganisms or viruses; sale or other disposal; permission required.

3202. Live pathogenic microorganisms or viruses; sale or other disposal; labeling containers.

3203. Live pathogenic microorganisms or viruses; violations; penalties.

§ 3200. Live pathogenic microorganisms or viruses; handling; registration required; exceptions. 1. No person other than a licensed practitioner of medicine, dentistry, or veterinary medicine or a person under the direct supervision of a licensed practitioner of medicine, dentistry, or veterinary medicine shall possess or cultivate live pathogenic microorganisms or viruses other than vaccine virus

(a) unless he has satisfied the commissioner, or, in the city of New York, the department of health of the city of New York, that such microorganisms or viruses in his possession will not become a menace to the public health, and,

(b) unless a registration number shall have been issued to him or his employer within the preceding twelve months by the commissioner, or in the city of New York, by the department of health of the city of New

York, or their authorized representatives.

2. (a) Where one or more persons work with such microorganisms or viruses, application for the registration number required by the provisions of this section shall be made by the person in charge of the work in connection with which such microorganisms or viruses are handled.

(b) If such person in charge is not a licensed practitioner of medicine, dentistry, or veterinary medicine, before a registration number is issued, he must first satisfy the commissioner, or in the city of New York, the department of health of the city of New York, that such microorganisms or viruses will not become a menace to the public health.

3. (a) If the same person remains in charge of the work, the registration number shall be valid through April thirtieth of each year and may be renewed upon application prior to its expiration.

(b) The registration number becomes invalid if a change is made in the person in charge of the work or the work is conducted at a different address, in which case a new application must be made.

4. A registration fee of one dollar shall be charged to cover the cost of issuing the registration number.

5. The provisions of this section shall not apply to laboratories maintained by the federal, state or municipal government.

6. The commissioner, or in the city of New York, the department of health of the city of New York, is authorized to rescind such registration number at any time for a cause.

§ 3201. Live pathogenic microorganisms or viruses; sale or other disposal; permission required. 1. No person shall sell or convey any live pathogenic microorganisms or viruses other than vaccine virus to any other person without permission of the commissioner, or in the city of New York without the permission of the department of health of the city of New York.

2. This section does not apply to diseased tissue, exudate, or other specimens which are sent by physicians, dentists or veterinarians to laboratories for examination as an aid in the diagnosis or control of disease.

§ 3202. Live pathogenic microorganisms or viruses; sale or other disposal; labeling containers. 1. All live pathogenic microorganisms or viruses other than vaccine virus when given away or sold shall bear a label on the container showing the contents of the container.

2. If the distributor is required to be registered, the label shall also bear the registration number assigned by the department, or in the city of New York by the department of health of such city, for the handling of pathogenic microorganisms or viruses, the name of the person obtaining the material, and the destination of the pathogenic microorganisms or viruses.

§ 3203. Live pathogenic microorganisms or viruses; violations; penalties. Any violation of this article shall be deemed a misdemeanor punishable by a fine of two hundred dollars, six months' imprisonment or both.

ARTICLE 32-A

RECOMBINANT DNA EXPERIMENTS

Section 3220. Findings.

3221. Definitions.

3222. Certification.

3223. Enforcement.

§ 3220. Findings. The legislature finds that new techniques of genetic manipulation which allow researchers to accomplish exchanges of genetic material between unlike organisms offer great potential for

expanding human knowledge of genetics but also may present significant risks to public health, to the environment and to the health of research workers. These experiments are being conducted at research institutions in New York, including universities, hospitals and industrial facilities. Industry plans to mass-produce recombinant organisms should such organisms be found to have commercial uses. Such research and production should only be conducted under safe conditions as prescribed by the commissioner.

§ 3221. Definitions. As used in this article:

1. "DNA" means deoxyribonucleic acid.
2. "Recombinant DNA" means DNA molecules which;
 - (a) have been formed by joining together DNA segments in a cell-free system and which have the capacity to enter a cell and to replicate in such cell either autonomously or after they have become an integrated part of such cell's genome; or
 - (b) are the result of a replication of the DNA molecules described in paragraph (a) of this subdivision.
3. "Recombinant DNA activity" means the possession of recombinant DNA by any person and any activity undertaken by any person for the production of recombinant DNA.
4. "Person" means any individual, corporation, partnership, or legal entity of any kind, or a governmental agency, board or body.
5. "Cell-free system" means an environment outside of any cell or cellular organism.

§ 3222. Certification. 1. One hundred eighty days after the effective date of this article, no individual shall engage in a recombinant DNA activity unless such individual has been issued a certificate by the commissioner or such individual is affiliated with and is acting under

the direction of and in a facility controlled by a person who has been issued such a certificate.

2. Within one hundred eighty days of the effective date of this article, the commissioner shall prescribe regulations for the conduct of recombinant DNA activity which shall be the substantial equivalent of sections II (entitled "containment") and III (entitled "experimental guidelines") of the recombinant DNA research guidelines of the National Institutes of Health of the Department of Health, Education and Welfare published in part II of the Federal Register for July seventh, nineteen hundred seventy-six. If the National Institutes of Health guidelines are revised, the commissioner shall revise the regulations for the conduct of recombinant DNA activity accordingly.

3. Within one hundred eighty days of the effective date of this article the commissioner shall prescribe regulations for the:

- (a) training and qualifications for individuals engaging in recombinant DNA activities;
- (b) personnel health monitoring programs;
- (c) establishment of institutional committees to oversee such activities; and
- (d) periodic reports of the progress of such activities.

Regulations adopted pursuant to this section shall be reviewed periodically by the commissioner in light of current scientific knowledge to determine their continued adequacy and appropriateness.

4. The commissioner shall by regulation, establish procedures for application for a certificate to conduct recombinant DNA activity. All proprietary information in applications or reports to the department by persons certified pursuant to this section, not available to the public or protected by a patent or copyright, shall be kept confidential.

5. The commissioner may approve or deny an application for a certificate to engage in recombinant DNA activity or may approve it upon such conditions as he shall prescribe.

6. The commissioner by regulation may prescribe reasonable fees for certification, not exceeding the cost of administrative services rendered by the department.

7. The commissioner shall, by regulation, provide for an abbreviated certification process for the conduct of recombinant DNA activity which is subject to, and which is in compliance with, policies and regulations promulgated by any agency of the federal government for the regulation of recombinant DNA activity.

8. No local authority shall enact or enforce any local law, ordinance, rule or regulation which would regulate or restrict recombinant DNA activity. Further, no local authority shall enact or duplicate any provision of this article as local law, ordinance, rule or regulation.

§ 3223. Enforcement. 1. The commissioner may conduct scheduled or unscheduled inspections of facilities where certified activities are being conducted.

2. The commissioner may suspend a certificate on the ground that the holder unreasonably refused to admit a department inspector to the premises where a recombinant DNA activity was taking place, or for any other violation of a regulation promulgated pursuant to this article. The commissioner shall hold a hearing within fifteen days following any such suspension to determine whether the suspension was reasonable. The commissioner may then annul the suspension, or if he finds the suspension to have been reasonable he may revoke the certificate or continue its suspension for a period not to exceed three months.

ARTICLE 33

CONTROLLED SUBSTANCES

TITLE I

GENERAL PROVISIONS

Section 3300. Short title.

3300-a. Legislative purposes.

- 3301. Applicability of this article to actions and matters occurring or arising before and after the effective date.
- 3302. Definitions of terms of general use in this article.
- 3304. Prohibited acts.
- 3304*. Prohibited acts.
- 3305. Exemptions.
- 3306. Schedules of controlled substances.
- 3307. Exception from schedules.
- 3308. Powers and duties of the commissioner.
- 3309. Opioid overdose prevention.
- 3309-a. Prescription pain medication awareness program.
- 3309-b. Dispensing of drug adulterant testing supplies.

TITLE II

MANUFACTURE AND DISTRIBUTION OF CONTROLLED SUBSTANCES

- Section 3310. Licenses for manufacture or distribution of controlled substances.
- 3311. Authority to issue initial licenses, amended licenses, and to renew licenses.
- 3312. Application for initial license.
- 3313. Granting of initial license.
- 3315. Applications for renewal of licenses to manufacture or distribute controlled substances.
- 3316. Granting of renewal of licenses.
- 3318. Identification of controlled substances.
- 3319. Distribution of free samples.
- 3320. Authorized distribution.
- 3321. Exempt distribution.
- 3322. Reports and records.

TITLE 2-A

OPIOID STEWARDSHIP ACT

- Section 3323. Opioid stewardship fund.

TITLE III

RESEARCH, INSTRUCTIONAL ACTIVITIES, AND CHEMICAL ANALYSIS RELATING TO CONTROLLED SUBSTANCES

- Section 3324. Licenses to engage in research, instructional activities, and chemical analysis relating to

controlled substances.

- 3325. Authority to issue licenses; applications.
- 3326. Institutional research licenses.
- 3327. Procedure.
- 3328. Exemptions from title.
- 3329. Reports and records.

TITLE IV

DISPENSING TO ULTIMATE USERS

- Section 3330. Schedule I substances.
- 3331. Scheduled substances administering and dispensing by practitioners.
- 3332. Making of official New York state prescriptions for scheduled substances.
- 3333. Dispensing upon official New York state prescription.
- 3334. Emergency oral prescriptions for schedule II drugs and certain other controlled substances.
- 3337. Oral prescriptions schedule III, IV and V substances.
- 3338. Official New York state prescription forms.
- 3339. Refilling of prescriptions for controlled substances.
- 3341. Institutional dispensers certificates of approval.
- 3342. Dispensing and administering by institutional dispensers.
- 3343. Reports and records.
- 3343-a. Prescription monitoring program registry.
- 3345. Possession of controlled substances by ultimate users original container.

TITLE V

DISPENSING TO PERSONS WITH SUBSTANCE USE DISORDER AND HABITUAL USERS

- Section 3350. Dispensing prohibition.
- 3351. Dispensing for medical use.
- 3352. Reports and records.

TITLE V-A

MEDICAL USE OF MARIHUANA

- Section 3360. Definitions.
- 3361. Certification of patients.
- 3362. Lawful medical use.
- 3363. Registry identification cards.

- 3364. Registered organizations.
- 3365. Registering of registered organizations.
- 3365-a. Expedited registration of registered organizations.
- 3366. Reports by registered organizations.
- 3367. Evaluation; research programs; report by department.
- 3368. Relation to other laws.
- 3369. Protections for the medical use of marihuana.
- 3369-a. Regulations.
- 3369-b. Effective date.
- 3369-c. Suspend; terminate.
- 3369-d. Pricing.
- 3369-e. Severability.

TITLE VI

RECORDS AND REPORTS

- Section 3370. Preserving and inspection of records.
- 3371. Confidentiality of certain records, reports, and information.
- 3373. Confidential communications.
- 3374. Notification by licensee.

TITLE VII

OFFENSES, VIOLATIONS AND ENFORCEMENT

- Section 3380. Inhalation of certain toxic vapors or fumes and certain hazardous inhalants; sale of glue and hazardous inhalants in certain cases.
- 3381. Sale and possession of hypodermic syringes and hypodermic needles.
- 3381-a. Destruction of hypodermic syringes and needles.
- 3383. Imitation controlled substances.
- 3384. Information program for retailers.
- 3385. Enforcement.
- 3387. Seizure and forfeiture of controlled substances, imitation controlled substances and official New York state prescription forms; disposition.
- 3388. Seizure and forfeiture of vehicles, vessels or aircraft unlawfully used to conceal, convey or transport controlled substances.
- 3390. Revocation of licenses and certificates of approval.

- 3391. Revocation and suspension of license or certificate of approval procedure.
- 3393. Formal hearings procedure.
- 3394. Judicial review.
- 3396. Violations; penalties.
- 3397. Fraud and deceit.

TITLE I

GENERAL PROVISIONS

- Section 3300. Short title.
- 3300-a. Legislative purposes.
 - 3301. Applicability of this article to actions and matters occurring or arising before and after the effective date.
 - 3302. Definitions of terms of general use in this article.
 - 3304. Prohibited acts.
 - 3305. Exemptions.
 - 3306. Schedules of controlled substances.
 - 3307. Exception from schedules.
 - 3308. Powers and duties of the commissioner.
 - 3309. Opioid overdose prevention.
 - 3309-a. Prescription pain medication awareness program.
 - 3309-b. Dispensing of drug adulterant testing supplies.

§ 3300. Short title. This article shall be known as the New York State Controlled Substances Act.

§ 3300-a. Legislative purposes. The purposes of this article are:

1. to combat illegal use of and trade in controlled substances; and
2. to allow legitimate use of controlled substances in health care, including palliative care; veterinary care; research and other uses authorized by this article or other law; under appropriate regulation

and subject to this article, title eight of the education law, and other applicable law.

§ 3301. Applicability of this article to actions and matters occurring or arising before and after the effective date. Unless otherwise expressly provided, or unless the context otherwise requires:

(a) the provisions of this article shall govern and control the possession, manufacture, dispensing, administering, and distribution of controlled substances with respect to any matter, act or omission, arising or occurring on or after the effective date hereof;

(b) the provisions of this article do not apply to or govern any matter, act, or omission arising or occurring prior to the effective date hereof. Such matters, acts, or omissions must be governed and construed according to provisions of law existing at the time such matter, act or omission arose or occurred in the same manner as if this article had not been enacted.

§ 3302. Definitions of terms of general use in this article. Except where different meanings are expressly specified in subsequent provisions of this article, the following terms have the following meanings:

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

2. "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject.

3. "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. No person may be authorized to so act if under title VIII of the education law such person would not be permitted to engage in such conduct. It does not include a common or contract carrier, public warehouseman, or employee

of the carrier or warehouseman when acting in the usual and lawful course of the carrier's or warehouseman's business.

4. "Controlled substance" means a substance or substances listed in section thirty-three hundred six of this title.

5. "Commissioner" means commissioner of health of the state of New York.

6. "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship.

7. "Department" means the department of health of the state of New York.

8. "Dispense" means to deliver a controlled substance to an ultimate user or research subject by lawful means, including by means of the internet, and includes the packaging, labeling, or compounding necessary to prepare the substance for such delivery.

9. "Distribute" means to deliver a controlled substance, including by means of the internet, other than by administering or dispensing.

10. "Distributor" means a person who distributes a controlled substance.

11. "Diversion" means manufacture, possession, delivery or use of a controlled substance by a person or in a manner not specifically authorized by law.

12. "Drug" means

(a) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals; and

(c) substances (other than food) intended to affect the structure or a function of the body of man or animal. It does not include devices or their components, parts, or accessories.

13. "Federal agency" means the Drug Enforcement Administration, United States Department of Justice, or its successor agency.

14. "Federal controlled substances act" means the Comprehensive Drug Abuse Prevention and Control Act of 1970, Public Law 91-513, and any act or acts amendatory or supplemental thereto or regulations promulgated thereunder.

15. "Federal registration number" means such number assigned by the Federal agency to any person authorized to manufacture, distribute, sell, dispense or administer controlled substances.

16. "Habitual user" means any person who is, or by reason of repeated use of any controlled substance for non-legitimate or unlawful use is in danger of becoming, dependent upon such substance.

17. "Institutional dispenser" means a hospital, veterinary hospital, clinic, dispensary, maternity home, nursing home, mental hospital or similar facility approved and certified by the department as authorized to obtain controlled substances by distribution and to dispense and administer such substances pursuant to the order of a practitioner.

18. "License" means a written authorization issued by the department or the New York state department of education permitting persons to engage in a specified activity with respect to controlled substances.

19. "Manufacture" means the production, preparation, propagation, compounding, cultivation, conversion or processing of a controlled substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the

preparation, compounding, packaging or labeling of a controlled substance:

(a) by a practitioner as an incident to his administering or dispensing of a controlled substance in the course of his professional practice; or

(b) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale; or

(c) by a pharmacist as an incident to his dispensing of a controlled substance in the course of his professional practice.

20. "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(a) opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate;

(b) any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph (a) of this subdivision, but not including the isoquinoline alkaloids of opium;

(c) opium poppy and poppy straw.

21. "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under section thirty-three hundred six of this title, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

22. "Opium poppy" means the plant of the species *Papaver somniferum* L., except its seeds.

23. "Person" means individual, institution, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

24. "Pharmacist" means any person licensed by the state department of education to practice pharmacy.

25. "Pharmacy" means any place registered as such by the New York state board of pharmacy and registered with the Federal agency pursuant to the federal controlled substances act.

26. "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

27. "Practitioner" means:

A physician, dentist, podiatrist, veterinarian, scientific investigator, or other person licensed, or otherwise permitted to dispense, administer or conduct research with respect to a controlled substance in the course of a licensed professional practice or research licensed pursuant to this article. Such person shall be deemed a "practitioner" only as to such substances, or conduct relating to such substances, as is permitted by his license, permit or otherwise permitted by law.

28. "Prescribe" means a direction or authorization, by prescription, permitting an ultimate user lawfully to obtain controlled substances from any person authorized by law to dispense such substances.

29. "Prescription" shall mean an official New York state prescription, an electronic prescription, an oral prescription or an out-of-state prescription.

30. "Sell" means to sell, exchange, give or dispose of to another, or offer or agree to do the same.

31. "Ultimate user" means a person who lawfully obtains and possesses a controlled substance for his own use or the use by a member of his household or for an animal owned by him or in his custody. It shall also mean and include a person designated, by a practitioner on a

prescription, to obtain such substance on behalf of the patient for whom such substance is intended.

32. "Internet" means collectively computer and telecommunications facilities which comprise the worldwide network of networks that employ a set of industry standards and protocols, or any predecessor or successor protocol to such protocol, to exchange information of all kinds. "Internet," as used in this article, also includes other networks, whether private or public, used to transmit information by electronic means.

33. "By means of the internet" means any sale, delivery, distribution, or dispensing of a controlled substance that uses the internet, is initiated by use of the internet or causes the internet to be used.

34. "Online dispenser" means a practitioner, pharmacy, or person in the United States that sells, delivers or dispenses, or offers to sell, deliver, or dispense, a controlled substance by means of the internet.

35. "Electronic prescription" means a prescription issued with an electronic signature and transmitted by electronic means in accordance with regulations of the commissioner and the commissioner of education and consistent with federal requirements. A prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription and must be manually signed.

36. "Electronic" means of or relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities. "Electronic" shall not include facsimile.

37. "Electronic record" means a paperless record that is created, generated, transmitted, communicated, received or stored by means of electronic equipment and includes the preservation, retrieval, use and disposition in accordance with regulations of the commissioner and the commissioner of education and in compliance with federal law and regulations.

38. "Electronic signature" means an electronic sound, symbol, or process, attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the record, in accordance with regulations of the commissioner and the commissioner of education.

39. "Registry" or "prescription monitoring program registry" means the prescription monitoring program registry established pursuant to section thirty-three hundred forty-three-a of this article.

40. "Compounding" means the combining, admixing, mixing, diluting, pooling, reconstituting, or otherwise altering of a drug or bulk drug substance to create a drug with respect to an outsourcing facility under section 503B of the federal Food, Drug and Cosmetic Act and further defined in this section.

41. "Outsourcing facility" means a facility that:

(a) is engaged in the compounding of sterile drugs as defined in section sixty-eight hundred two of the education law;

(b) is currently registered as an outsourcing facility pursuant to article one hundred thirty-seven of the education law; and

(c) complies with all applicable requirements of federal and state law, including the Federal Food, Drug and Cosmetic Act.

Notwithstanding any other provision of law to the contrary, when an outsourcing facility distributes or dispenses any drug to any person pursuant to a prescription, such outsourcing facility shall be deemed to be providing pharmacy services and shall be subject to all laws, rules and regulations governing pharmacies and pharmacy services.

*** § 3304. Prohibited acts.** 1. It shall be unlawful for any person to manufacture, sell, prescribe, distribute, dispense, administer, possess, have under his control, abandon, or transport a controlled substance except as expressly allowed by this article.

2. It shall be unlawful for any person to possess or have under his

control an official New York state prescription form except as expressly allowed by this article.

* NB Separately amended -- cannot be put together

* § 3304. Prohibited acts. a. It shall be unlawful for any person to manufacture, sell, prescribe, distribute, dispense, administer, possess, have under his control, abandon, or transport a controlled substance except as expressly allowed by this article.

b. It shall be unlawful for any physician practicing medicine as defined in section sixty-five hundred twenty-one of the education law to prescribe, dispense or administer any amphetamines or sympathomimetic amine drug or compound thereof, designated as a schedule II controlled substance pursuant to section thirty-three hundred six of this article for the exclusive treatment of obesity, weight control or weight loss. A violation of the provisions of this subdivision shall not be grounds for prosecution under article two hundred twenty of the penal law.

* NB Separately amended -- cannot be put together

§ 3305. Exemptions. 1. The provisions of this article restricting the possession and control of controlled substances and official New York state prescription forms shall not apply:

(a) to common carriers or to warehousemen, while engaged in lawfully transporting or storing such substances, or to any employee of the same acting within the scope of his employment; or

(b) to public officers or their employees in the lawful performance of their official duties requiring possession or control of controlled substances; or

(c) to temporary incidental possession by employees or agents of persons lawfully entitled to possession, or by persons whose possession is for the purpose of aiding public officers in performing their official duties.

(d) to a duly authorized agent of an incorporated society for the prevention of cruelty to animals or a municipal animal control facility for the limited purpose of buying, possessing, and dispensing to registered and certified personnel, ketamine hydrochloride to anesthetize animals and/or sodium pentobarbital to euthanize animals,

including but not limited to dogs and cats. The department shall, consistent with the public interest, register such duly authorized agent and such agent shall file, on a quarterly basis, a report of purchase, possession, and use of ketamine hydrochloride and/or sodium pentobarbital, which report shall be certified by the society for the prevention of cruelty to animals or municipal animal control facility as to its accuracy and validity. This report shall be in addition to any other record keeping and reporting requirements of state and federal law and regulation. The department shall adopt rules and regulations providing for the registration and certification of any individual who, under the direction of the duly authorized and registered agent of an incorporated society for the prevention of cruelty to animals, or municipal animal control facility, uses ketamine hydrochloride to anesthetize animals and/or sodium pentobarbital to euthanize animals, including but not limited to dogs and cats. The department may also adopt such other rules and regulations as shall provide for the safe and efficient use of ketamine hydrochloride and/or sodium pentobarbital by incorporated societies for the prevention of cruelty to animals and animal control facilities. Nothing in this paragraph shall be deemed to waive any other requirement imposed on incorporated societies for the prevention of cruelty to animals and animal control facilities by state and federal law and regulation.

2. The commissioner may, by regulation, provide for the exemption from all or part of the requirements of this article the possession of substances in schedule III or IV and use thereof as part of an industrial process or manufacture of substances other than drugs. The commissioner may impose such conditions upon the granting of such exemption as may be necessary to protect against diversion or misuse of the controlled substance.

3. The commissioner is hereby authorized and empowered to make any rules, regulations and determinations permitting the following categories of persons to obtain, dispense and administer controlled substances under such conditions and in such manner as he shall prescribe:

(a) a person in the employ of the United States government or of any

state, territory, district, county, municipal, or insular government, obtaining, possessing, dispensing and administering controlled substances by reason of his official duties;

(b) a master of a ship or a person in charge of any aircraft upon which no physician is regularly employed, or to a physician or surgeon duly licensed in any state, territory, or the District of Columbia to practice his profession, or to a retired commissioned medical officer of the United States army, navy, or public health service, employed upon such ship or aircraft, for the actual medical needs of persons on board such ship or aircraft when not in port.

(c) a person in a foreign country in compliance with the provisions of this article.

4. The provisions of this article with respect to the payment of fees and costs shall not apply to the state of New York or any political subdivision thereof or any agency or instrumentality of either.

§ 3306. Schedules of controlled substances. There are hereby established five schedules of controlled substances, to be known as schedules I, II, III, IV and V respectively. Such schedules shall consist of the following substances by whatever name or chemical designation known:

Schedule I. (a) Schedule I shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation (for purposes of 3-methylfentanyl only, the term isomer includes the optical and geometric isomers):

- (1) Acetyl-alpha-methylfentanyl
(N-{1-(-methyl-2-phenethyl) -4-piperidinyl} -N-phenylacetamide.
- (2) Acetylmethadol.
- (3) Allylprodine.

- (4) Alphacetylmethadol (except levo- alphacetylmethadol also known as levo-alpha-acetylmethadol, levomethadylacetate or LAAM).
- (5) Alphameprodine.
- (6) Alphamethadol.
- (7) Alpha-methylfentanyl (N-{1-(alpha-methyl-beta-phenyl) ethyl-4-piperidyl} propionanilide; 1-(1-methyl-2-phenylethyl) -4-(N-propanilido) piperidine).
- (8) Alpha-methylthiofentanyl (N-{1-methyl-2)2-thienyl) ethyl-4-piperidinyl} -N-phenylpropanamide).
- (9) Beta-hydroxyfentanyl (N-{1-2 (2-hydroxy-2-phenethyl)- 4-piperidinyl} -N-phenylpropanamide).
- (10) Beta-hydroxy-3-methylfentanyl (other name: N-{1-(2-hydroxy-2-phenethyl) -3-methyl -4-piperidinyl} -N-phenylpropanamide).
- (11) Benzethidine.
- (12) Betacetylmethadol.
- (13) Betameprodine.
- (14) Betamethadol.
- (15) Betaprodine.
- (16) Clonitazene.
- (17) Dextromoramide.
- (18) Diampromide.
- (19) Diethylthiambutene.
- (20) Difenoxyin.
- (21) Dimenoxadol.
- (22) Dimepheptanol.
- (23) Dimethylthiambutene.
- (24) Dioxaphetyl butyrate.
- (25) Dipipanone.
- (26) Ethylmethylthiambutene.
- (27) Etonitazene.
- (28) Etoxeridine.
- (29) Furethidine.
- (30) Hydroxypethidine.
- (31) Ketobemidone.
- (32) Levomoramide.
- (33) Levophenacylmorphane.
- (34) 3-Methylfentanyl (N-{3-methyl-1-(2- phenylethyl -4-piperidyl}

-N-phenylpropanamide).

(35) 3-Methylthiofentanyl (N-{3-methyl-1- (2-thienyl)ethyl
-4-piperidinyl} -N-phenylpropanamide).

(36) Morpheridine.

(37) MPPP (1-methyl -4-phenyl -4-propionoxypiperidine).

(38) Noracymethadol.

(39) Norlevorphanol.

(40) Normethadone.

(41) Norpipanone.

(42) Para-fluorofentanyl (N- (4-fluorophenyl) -N-{1- (2-phenethyl)
-4-piperidinyl} -propanamide.

(43) PEPAP (1- (-2-phenethyl) -4-phenyl -4-acetoxypiperidine.

(44) Phenadoxone.

(45) Phenampromide.

(46) Phenomorphan.

(47) Phenoperidine.

(48) Piritramide.

(49) Proheptazine.

(50) Properidine.

(51) Propiram.

(52) Racemoramide.

(53) Thiofentanyl (N-phenyl-N-{1- (2-thienyl) ethyl -4- piperidinyl}
-propanamide.

(54) Tilidine.

(55) Trimeperidine.

(56) 3,4-dichloro-N-{(1-dimethylamino)cyclohexylmethyl}benzamide.

Some trade or other names: AH-7921.

(57) N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Some trade or
other names: Acetyl Fentanyl.

(58) N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide. Other name:
Butyryl Fentanyl.

(59) N-{1-{2-hydroxy-2-(thiophen-2-yl)ethyl}piperidin-4-yl}-N-
phenylpropionamide. Other name: Beta-Hydroxythiofentanyl.

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide. Other
name: Furanyl Fentanyl.

(61) 3,4-Dichloro-N-{2-(dimethylamino)cyclohexyl}-N-methylbenzamide.
Other name: U-47700.

(62) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names: Acryl Fentanyl or Acryloylfentanyl.

(63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

(64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

(66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide. Other name: cyclopropyl fentanyl.

(68) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-fluorobutyrylfentanyl.

(69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide. Other name: Ocfentanil.

(70) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.

(71) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide. Other name: Valeryl fentanyl.

(72) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-methoxybutyryl fentanyl.

(73) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: para-chloroisobutyryl fentanyl.

(74) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Other name: isobutyryl fentanyl.

(75) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide. Other name: cyclopentyl fentanyl.

(76) (E)-N-(1-phenethylpiperidin-4-yl)-N-phenylbut-2-enamide. Other name: crotonyl fentanyl.

(77) N-(1-(2-fluorophenethyl)piperidin-4-yl)-N-(2-fluorophenyl)propionamide. Other names: 2'-fluoro ortho-fluorofentanyl; 2'-fluoro 2-fluorofentanyl.

(78) N-(2-methylphenyl)-N-(1-phenethylpiperidin-4-yl)acetamide. Other names: ortho-methyl acetylfentanyl; 2-methyl acetylfentanyl.

(79) N-(1-phenethylpiperidin-4-yl)-N, 3-diphenylpropanamide. Other names: beta'-phenyl fentanyl; beta'-phenyl fentanyl; 3-phenylpropanoyl

fentanyl.

(80) N-(1-phenethylpiperidin-4-yl)-N-phenylthiophene-2-carboxamide. Other names: thiofuranyl fentanyl; 2-thiofuranyl fentanyl; thiophene fentanyl.

(81) N-phenyl-N-(1-(2-phenylpropyl)piperidin-4-yl)propionamide. Other names: beta-Methyl fentanyl; beta-methyl fentanyl.

(82) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other names: ortho-fluorobutyryl fentanyl; 2-fluorobutyryl fentanyl.

(83) N-(1-(4-methylphenethyl)piperidin-4-yl)-N-phenylacetamide. Other name: 4'-methyl acetyl fentanyl.

(84) 2-methoxy-N-(2-methylphenyl)-N-(1-phenethylpiperidin-4-yl)acetamide. Other names: ortho-methyl methoxyacetylfentanyl; 2-methyl methoxyacetyl fentanyl.

(85) N-(4-methylphenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: para-methylylfentanyl; 4-methylylfentanyl.

(86) N-(1-phenethylpiperidin-4-yl)-N-phenylbenzamide. Other names: phenyl fentanyl; benzoyl fentanyl.

(87) ethyl (1-phenethylpiperidin-4-yl)(phenyl)carbamate. Other name: Fentanyl carbamate.

(88) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)acrylamide. Other name: ortho-fluoroacryl fentanyl.

(89) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: ortho-fluoroisobutyryl fentanyl.

(90) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)furan-2-carboxamide. Other name: para-fluoro furanyl fentanyl.

(91) N,N-diethyl-2-(2-(4-isopropoxybenzyl)-5-nitro-1H-benzimidazol-1-yl)ethan-1-amine. Other name: Isotonitazene.

(92) 1-(1-(1-(4-bromophenyl)ethyl)piperidin-4-yl)-1,3-dihydro-2H-benzo[d]imidazol-2-one. Other names: Brorphine; 1-{1-{1-(4-bromophenyl)ethyl}-4-piperidinyl}-1,3-dihydro-2H-benzimidazol-2-one.

(c) Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine.

(2) Acetyldihydrocodeine.

- (3) Benzylmorphine.
- (4) Codeine methylbromide.
- (5) Codeine-N-oxide.
- (6) Cyprenorphine.
- (7) Desomorphine.
- (8) Dihydromorphine.
- (9) Drotebanol.
- (10) Etorphine (except hydrochloride salt).
- (11) Heroin.
- (12) Hydromorphenol.
- (13) Methyldesorphine.
- (14) Methyldihydromorphine.
- (15) Morphine methylbromide.
- (16) Morphine methylsulfonate.
- (17) Morphine-N-oxide.
- (18) Myrophine.
- (19) Nicocodeine.
- (20) Nicomorphine.
- (21) Normorphine.
- (22) Pholcodine.
- (23) Thebacon.

(d) Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term "isomer" includes the optical, position and geometric isomers):

(EXPLANATION--Within the following chemical designations, character

symbol substitutions were made from the original text: "@" = Greek

alpha, "&" = Greek beta, "'" = prime mark and "/\" = triangle.)

(1) 4-bromo-2, 5-dimethoxy-amphetamine Some trade or other names:
4-bromo-2, 5-dimethoxy-@-methylphenethylamine; 4-bromo-2, 5-DMA.

(2) 2, 5-dimethoxyamphetamine Some trade or other names:

2, 5-dimethoxy-@-methylphenethylamine; 2, 5-DMA.

(3) 4-methoxyamphetamine Some trade or other names:

4-methoxy-@-methylphenethylamine; paramethoxyamphetamine, PMA.

(4) 5-methoxy-3, 4-methylenedioxy - amphetamine.

(5) 4-methyl-2, 5-dimethoxy-amphetamine Some trade and other names:

4-methyl-2, 5-dimethoxy-@-methylphenethylamine; "DOM"; and "STP".

(6) 3, 4-methylenedioxy amphetamine.

(7) 3, 4, 5-trimethoxy amphetamine.

(8) Bufotenine Some trade and other names: 3-(@-dimethylaminoethyl)-5-hydroxyindole; 3-(2-dimethylaminoethyl)- 5-indolol;

N, N-dimethylserotonin; -5-hydroxy-N, N-dimethyltryptamine; mappine.

(9) Diethyltryptamine Some trade and other names:

N, N-diethyltryptamine; DET.

(10) Dimethyltryptamine Some trade or other names: DMT.

(11) Ibogane Some trade and other names: 7-ethyl-6, 6&, 7, 8, 9, 10, 12, 13-octahydro-2-methoxy-6, 9-methano-5h-pyrido {1',2':1,2} azepino {5,4-b} indole: tabernanthe iboga.

(12) Lysergic acid diethylamide.

(13) Mescaline.

(14) Parahexyl. Some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetra hydro-6,6,9-trimethyl-6H-dibenfo{b,d} pyran.

(15) Peyote. Meaning all parts of the plant presently classified botanically as *Lophophora williamsii* Lemaire, whether growing or not, the seeds thereof, any extract from any part of such plant, and every compound, manufacture, salts, derivative, mixture, or preparation of such plant, its seeds or extracts.

(16) N-ethyl-3-piperidyl benzilate.

(17) N-methyl-3-piperidyl benzilate.

(18) Psilocybin.

(19) Psilocyn.

(20) Tetrahydrocannabinols. Synthetic tetrahydrocannabinols not derived from the cannabis plant that are equivalents of the substances contained in the plant, or in the resinous extractives of cannabis, sp. and/or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:

delta 1 cis or trans tetrahydrocannabinol, and their optical isomers

delta 6 cis or trans tetrahydrocannabinol, and their optical isomers

delta 3, 4 cis or trans tetrahydrocannabinol, and its optical isomers (since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions covered). Any Federal Food and Drug Administration approved product containing tetrahydrocannabinol shall not be considered a synthetic tetrahydrocannabinol.

(21) Ethylamine analog of phencyclidine. Some trade or other names: N-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl) ethylamine cyclohexamine, PCE.

(22) Pyrrolidine analog of phencyclidine. Some trade or other names 1-(1-phenylcyclohexyl)-pyrrolidine; PCPy, PHP.

(23) Thiophene analog of phencyclidine. Some trade or other names: 1-{1-(2-thienyl)-cyclohexyl}-piperidine, 2-thienylanalog of phencyclidine, TPCP, TCP.

(24) 3,4-methylenedioxymethamphetamine (MDMA).

(25) 3,4-methylenedioxy-N-ethylamphetamine (also known as N-ethyl-alpha-methyl-3,4 (methylenedioxy) phenethylamine, N-ethyl MDA, MDE, MDEA.

(26) N-hydroxy-3,4-methylenedioxyamphetamine (also known as N-hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine, and N-hydroxy MDA.

(27) 1-{1- (2-thienyl) cyclohexyl} pyrrolidine. Some other names: TCPY.

(28) Alpha-ethyltryptamine. Some trade or other names: etryptamine; Monase; Alpha-ethyl-1H-indole-3-ethanamine; 3- (2-aminobutyl) indole; Alpha-ET or AET.

(29) 2,5-dimethoxy-4-ethylamphetamine. Some trade or other names: DOET.

(30) 4-Bromo-2,5-dimethoxyphenethylamine. Some trade or other names: 2-(4-bromo-2,5-dimethoxyphenyl)-1-aminoethane; alpha-desmethyl DOB; 2C-B, Nexus.

(31) 2,5-dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7), its optical isomers, salts and salts of isomers.

(33) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine,

also known as 25I-NBOMe; 2C-I-NBOMe; 25I; or Cimbi-5.

(34) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, also known as 25 CNBOMe; 2C-C-NBOMe; 25C; or Cimbi-82.

(35) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, also known as, 25 BNBOMe; 2C-B-NBOMe; Cimbi-36.

(36) 5-methoxy-N,N-dimethyltryptamine.

(37) Alpha-methyltryptamine. Some trade or other names: AMT.

(38) 5-methoxy-N,N-diisopropyltryptamine. Some trade or other names: 5-MeO-DIPT.

(e) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Mecloqualone.

(2) Methaqualone.

(3) Phencyclidine.

(4) Gamma hydroxybutyric acid, and salt, hydroxybutyric compound, derivative or preparation of gamma hydroxybutyric acid, including any isomers, esters and ethers and salts of isomers, esters and ethers of gamma hydroxybutyric acid, except gamma-butyrolactone, whenever the existence of such isomers, esters and ethers and salts is possible within the specific chemical.

(5) Gamma-butyrolactone, including butyrolactone; butyrolactone gamma; 4-butyrolactone; 2(3H)-furanone dihydro; dihydro-2(3H)-furanone; tetrahydro-2-furanone; 1,2-butanolide; 1,4-butanolide; 4-butanolide; gamma-hydroxybutyric acid lactone; 3-hydroxybutyric acid lactone and 4-hydroxybutanoic acid lactone with Chemical Abstract Service number (96-48-0) when any such substance is intended for human consumption.

(6) 1,4 butanediol, including butanediol; butane-1,4-diol; 1,4-butylene glyco; butylene glycol; 1,4-dihydroxybutane; 1,4-tetramethylene glycol; tetramethylene glycol; tetramethylene Abstract Service number (110-63-4) when any such substance is intended for human consumption.

(f) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which

contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

- (1) Fenethylamine.
- (2) N-ethylamphetamine.
- (3) (+ -)cis-4-methylaminorex ((+ -)cis-4,5-dihydro-4-methyl -5-phenyl -2-oxazoline).
- (4) N,N-dimethylamphetamine (also known as N,N-alpha-trimethyl-benzeneethanamine; N,N-alpha-trimethylphenethylamine).
- (5) Methcathinone (some other names: 2-(methylamino) - propiophenone; alpha-(methylamino) propiophenone; 2-(methylamino) -1-phenylpropan-1-one; alpha-N-methylaminopropiophenone; monomethylpropion; ephedrone, N-methylcathinone, methylcathinone; AL-464; AL-422; AL-463 and UR1432), its salts, optical isomers and salts of optical isomers.
- (6) Aminorex. Some other names: aminoxaphen; 2-amino-5-phenyl -2-oxazoline; or 4,5-dihydro-5-phenyl-2-oxazoline.
- (7) Cathinone. Some trade or other names: 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone, and norephedrone.
- (8) N-benzylpiperazine (some other names: BZP; 1-benzylpiperazine), its optical isomers, salts and salts of isomers.
- (9) 4-methyl-N-methylcathinone or 4-Methylmethcathinone, also known as Mephedrone.
- (10) 3,4-methylenedioxypyrovalerone or Methylenedioxypyrovalerone, also known as MDPV.
- (11) 3,4-methylenedioxy-N-methylcathinone (some other names: methylone).
- (12) 4-Methoxymethcathinone.
- (13) 3-Fluoromethcathinone.
- (14) 4-Fluoromethcathinone.
- (15) Ethylpropion (Ethcathinone).
- (16) 2-(2,5-Dimethoxy-4-ethylphenyl)ethanamine (2C-E).
- (17) 2-(2,5-Dimethoxy-4-methylphenyl)ethanamine (2C-D).
- (18) 2-(4-Chloro-2,5-dimethoxyphenyl)ethanamine (2C-C).
- (19) 2-(4-Iodo-2,5-dimethoxyphenyl)ethanamine (2C-I).
- (20) 2-{4-(Ethylthio)-2,5-dimethoxyphenyl}ethanamine (2C-T-2).
- (21) 2-{4-(Isopropylthio)-2,5-dimethoxyphenyl}ethanamine (2C-T-4).

(22) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H).

(23) 2-(2,5-Dimethoxy-4-nitro-phenyl)ethanamine (2C-N).

(24) 2-(2,5-Dimethoxy-4-(n)-propylphenyl)ethanamine (2C-P).

(g) Synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following synthetic cannabinoid substances, or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this paragraph only, the term "isomer" includes the optical, position and geometric isomers):

(1) (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade or other names: UR-144.

(2) {1-(5-fluoro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade names or other names: 5-fluoro-UR-144, XLR11.

(3) N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: APINACA, AKB48.

(4) quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate. Some trade or other names: PB-22; QUPIC.

(5) quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate. Some trade or other names: 5-fluoro-PB-22; 5F-PB-22.

(6) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-FUBINACA.

(7) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: ADB-PINACA.

(8) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: AB-CHMINACA.

(9) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide. Some trade or other names: AB-PINACA.

(10) {1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-yl)methanone. Some trade or other names: THJ-2201.

(h) (1) Cannabimimetic agents. Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation that is not approved by the federal food and drug administration (FDA) which contains any quantity of cannabimimetic agents, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is

possible within the specific chemical designation.

(2) As used in this subdivision, the term "cannabimimetic agents" means any substance that is a cannabinoid receptor type 1 (CB1 receptor) agonist as demonstrated by binding studies and functional assays within any of the following structural classes:

(i) 2-(3-hydroxycyclohexyl)phenol with substitution at the 5-position of the phenolic ring by alkyl or alkenyl, whether or not substituted on the cyclohexyl ring to any extent.

(ii) 3-(1-naphthoyl)indole or 3-(1-naphthylmethane)indole by substitution at the nitrogen atom of the indole ring, whether or not further substituted on the indole ring to any extent, whether or not substituted on the naphthoyl or naphthyl ring to any extent.

(iii) 3-(1-naphthoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted on the naphthoyl ring to any extent.

(iv) 1-(1-naphthylmethylene)indene by substitution of the 3-position of the indene ring, whether or not further substituted in the indene ring to any extent, whether or not substituted on the naphthyl ring to any extent.

(v) 3-phenylacetylindole or 3-benzoylindole by substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent, whether or not substituted on the phenyl ring to any extent.

(3) Such term includes:

(i) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP-47,497);

(ii) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (cannabicyclohexanol or CP-47,497 C8-homolog);

(iii) 1-pentyl-3-(1-naphthoyl)indole (JWH-018 and AM678);

(iv) 1-butyl-3-(1-naphthoyl)indole (JWH-073);

(v) 1-hexyl-3-(1-naphthoyl)indole (JWH-019);

(vi) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(vii) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(viii) 1-pentyl-3-[1-(4-methoxynaphthoyl)]indole (JWH-081);

(ix) 1-pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(x) 1-pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

- (xi) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM2201);
- (xii) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM694);
- (xiii) 1-pentyl-3-[(4-methoxy)-benzoyl]indole (SR-19 and RCS-4);
- (xiv) 1-cyclohexylethyl-3-(2-methoxyphenylacetyl)indole (SR-18 and RCS-8); and
- (xv) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

Schedule II. (a) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Substances, vegetable origin or chemical synthesis. Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, nalmefene, naloxone, and naltrexone, and their respective salts, but including the following:

1. Raw opium.
2. Opium extracts.
3. Opium fluid.
4. Powdered opium.
5. Granulated opium.
6. Tincture of opium.
7. Codeine.
8. Ethylmorphine.

9. Etorphine hydrochloride.

10. Hydrocodone (also known as dihydrocodeinone).

11. Hydromorphone.

12. Metopon.

13. Morphine.

14. Oxycodone.

15. Oxymorphone.

16. Thebaine.

17. Dihydroetorphine.

18. Oripavine.

(2) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in this section, except that these substances shall not include the isoquinoline alkaloids of opium.

(3) Opium poppy and poppy straw.

(4) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances including cocaine and ecgonine, their salts, isomers, and salts of isomers, except that the substances shall not include: (A) decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; or (B) {123I} ioflupane.

(5) Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrene alkaloids of the opium poppy).

(b-1) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following, or their salts calculated as the free anhydrous base

or alkaloid, in limited quantities as set forth below:

(1) Not more than three hundred milligrams of dihydrocodeinone (hydrocodone) per one hundred milliliters or not more than fifteen milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

(2) Not more than three hundred milligrams of dihydrocodeinone (hydrocodone) per one hundred milliliters or not more than fifteen milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

(c) Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts and salts of isomers, esters and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrophan and levopropoxyphene excepted:

(1) Alfentanil.

(2) Alphaprodine.

(3) Anileridine.

(4) Bezitramide.

(5) Bulk dextropropoxyphene (non-dosage forms).

(6) Carfentanil.

(7) Dihydrocodeine.

(8) Diphenoxylate.

(9) Fentanyl.

(10) Isomethadone.

(11) Levo-alpha-acetylmethadol (also known as levo-alpha-acetylmethadol, levomethadylacetate or LAAM).

(12) Levomethorphan.

(13) Levorphanol.

(14) Metazocine.

(15) Methadone.

(16) Methadone-intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane.

(17) Moramide-intermediate, 2-methyl-3-morpholino-1, 1--diphenylpropane--carboxylic acid.

(18) Pethidine (meperidine).

(19) Pethidine-intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine.

(20) Pethidine-intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate.

(21) Pethidine-intermediate-C, 1--methyl--4-- phenylpiperidine--4-- carboxylic acid.

(22) Phenazocine.

(23) Piminodine.

(24) Racemethorphan.

(25) Racemorphan.

(26) Sufentanil.

(27) Remifentanil.

(28) Tapentadol.

(29) Thiafentanil.

(d) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(1) Amphetamine.

(2) Methamphetamine.

(3) Phenmetrazine.

(4) Methylphenidate.

(5) Lisdexamfetamine.

(e) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Amobarbital.

(2) Glutethimide.

(3) Pentobarbital.

(4) Secobarbital.

(f) Hallucinogenic substances.

Nabilone: Another name for nabilone: (+,-)-trans
-3-(1,1-dimethylheptyl)-6, 6a, 7, 8, 10, 10a-hexahydro-1-hydroxy-6,
6-dimethyl-9H-dibenzo{b,d}pyran-9-one.

(g) Immediate precursors. Unless specifically excepted or unless

listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances:

(1) Immediate precursor to amphetamine and methamphetamine:

(i) Phenylacetone Some trade or other names: phenyl-2-propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;

(2) Immediate precursors to phencyclidine (PCP):

(i) 1-phenylcyclohexylamine;

(ii) 1-piperidinocyclohexanecarbonitrile (PCC).

(3) Immediate precursor to fentanyl:

(i) 4-anilino-N-phenylethylpiperidine (ANPP).

(ii) N-phenyl-N-(piperidin-4-yl)propionamide (Norfentanyl).

(h) Anabolic steroids. Unless specifically excepted or unless listed in another schedule, "anabolic steroid" shall mean any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogens, progestins, corticosteroids and dehydroepiandrosterone) and includes:

(1) 3{beta}, 17-dihydroxy-5a-androstane.

(2) 3{alpha}, 17{beta}-dihydroxy-5a-androstane.

(3) 5{alpha}-androstane-3,17-dione.

(4) 1-androstenediol (3{beta},17{beta}-dihydroxy-5{alpha}-androst-1-ene).

(5) 1-androstenediol (3{alpha},17{beta}-dihydroxy-5{alpha}-androst-1-ene).

(6) 4-androstenediol (3{beta}, 17{beta}-dihydroxy-androst-4-ene).

(7) 5-androstenediol (3{beta}, 17{beta}-dihydroxy-androst-5-ene).

(8) 1-androstenedione (5{alpha}-androst-1-en-3,17-dione).

(9) 4-androstenedione (androst-4-en-3,17-dione).

(10) 5-androstenedione (androst-5-en-3,17-dione).

(11) Bolasterone (7{alpha},17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one).

(12) Boldenone (17{beta}-hydroxyandrost-1, 4,-diene-3-one).

(13) Boldione (androst-1,4-diene-3,17-dione).

(14) Calusterone (7{beta}, 17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one).

(15) Clostebol (4-chloro-17{beta}-hydroxyandrost-4-en-3-one).

(16) Dehydrochloromethyltestosterone (4-chloro-17{beta}-hydroxy-17{alpha}-methyl-androst-1, 4-dien-3-one).

- (17) {Delta} 1-dihydrotestosterone (a.k.a. '1-testosterone') (17{beta}-hydroxy-5{alpha}-androst-1-en-3-one).
- (18) 4-dihydrotestosterone (17{beta}-hydroxy-androstan-3-one).
- (19) Drostanolone (17{beta}-hydroxy-2{alpha}-methyl-5{alpha}-androstan-3-one).
- (20) Ethylestrenol (17{alpha}-ethyl-17{beta}-hydroxyestr-4-ene).
- (21) Fluoxymesterone (9-fluoro-17{alpha}-methyl-11{beta}, 17 {beta}-dihydroxyandrost-4-en-3-one).
- (22) Formebolone (2-formyl-17{alpha}-methyl-11{alpha}, 17{beta}-dihydroxyandrost-1, 4-dien-3-one).
- (23) Furazabol (17{alpha}-methyl-17{beta}-hydroxyandrostan-2, 3-c-furazan).
- (24) 13{beta}-ethyl-17{beta}-hydroxygon-4-en-3-one.
- (25) 4-hydroxytestosterone (4, 17{beta}-dihydroxy-androst-4-en-3-one).
- (26) 4-hydroxy-19-nortestosterone (4, 17{beta}-dihydroxy-estr-4-en-3-one).
- (27) desoxymethyltestosterone (17{alpha}-methyl-5{alpha}-androst-2-en-17{beta}-ol) (a.k.a., madol).
- (28) Mestanolone (17{alpha}-methyl-17{beta}-hydroxy-5-androstan-3-one).
- (29) Mesterolone (1{alpha} methyl-17{beta}-hydroxy-5{alpha}-androstan-3-one).
- (30) Methandienone (17{alpha}-methyl-17{beta}-hydroxyandrost-1, 4-dien-3-one).
- (31) Methandriol (17{alpha}-methyl-3{beta}, 17{beta}-dihydroxyandrost-5-ene).
- (32) Methenolone (1-methyl-17{beta}-hydroxy-5{alpha}-androst-1-en-3-one).
- (33) 17{alpha}-methyl-3{beta}, 17{beta}-dihydroxy-5a-androstane.
- (34) 17{alpha}-methyl-3{alpha}, 17{beta}-dihydroxy-5a-androstane.
- (35) 17{alpha}-methyl-3{beta}, 17{beta}-dihydroxyandrost-4-ene.
- (36) 17{alpha}-methyl-4-hydroxynandrolone (17{alpha}-methyl-4-hydroxy-17{beta}-hydroxyestr-4-en-3-one).
- (37) Methyldienolone (17{alpha}-methyl-17{beta}-hydroxyestra-4,9(10)-dien-3-one).
- (38) Methyltrienolone (17{alpha}-methyl-17{beta}-hydroxyestra-4,9-11-trien-3-one).

(39) Methyltestosterone (17{alpha}-methyl-17{beta}-hydroxyandrost-4-en-3-one).

(40) Mibolerone (7{alpha},17{alpha}-dimethyl-17{beta}-hydroxyestr-4-en-3-one).

(41) 17{alpha}-methyl-{Delta} 1-dihydrotestosterone (17b{beta}-hydroxy-17{alpha}-methyl-5{alpha}-androst-1-en-3-one) (a.k.a. '17-{alpha}-methyl-1-testosterone').

(42) Nandrolone(17{beta}-hydroxyestr-4-en-3-one).

(43) 19-nor-4-androstenediol (3{beta},17{beta}-dihydroxyestr -4-ene).

(44) 19-nor-4-androstenediol (3{alpha},17{beta}-dihydroxyestr-4-ene).

(45) 19-nor-5-androstenediol (3{beta},17{beta}-dihydroxyestr -5-ene).

(46) 19-nor-5-androstenediol (3{alpha},17{beta}-dihydroxyestr-5-ene).

(47) 19-nor-4,9(10)-androstadienedione (estra-4,9(10)-diene-3,17-dione).

(48) 19-nor-4-androstenedione (estr-4-en-3,17-dione).

(49) 19-nor-5-androstenedione (estr-5-en-3,17-dione).

(50) Norbolethone (13{beta}, 17{alpha}-diethyl-17{beta}-hydroxygon-4-en-3-one).

(51) Norclostebol (4-chloro-17{beta}-hydroxyestr-4-en-3-one).

(52) Norethandrolone (17{alpha}-ethyl-17{beta}-hydroxyestr-4-en-3-one).

(53) Normethandrolone (17{alpha}-methyl-17{beta}-hydroxyestr-4-en-3-one).

(54) Oxandrolone (17{alpha}-methyl-17{beta}-hydroxy-2-oxa-{5{alpha}}-androstan-3-one).

(55) Oxymesterone (17{alpha}-methyl-4, 17{beta}-dihydroxy androst-4-en-3-one).

(56) Oxymetholone (17 {alpha}-methyl-2-hydroxymethylene-17 {beta}-hydroxy-{5{alpha}}- androstan-3-one).

(57) Stanozolol (17{alpha}-methyl-17{beta}-hydroxy-{5{alpha}}-androst-2-eno{3, 2-c}-pyrazole).

(58) Stenbolone (17{beta}-hydroxy-2-methyl-{5{alpha}}-androst-1-en-3-one).

(59) Testolactone (13-hydroxy-3-oxo-13, 17-secoandrosta-1,4-dien-17-oic acid lactone).

(60) Testosterone (17{beta}-hydroxyandrost-4-en-3-one).

(61) Tetrahydrogestrinone (13{beta}, 17{alpha}-diethyl

-17{beta}-hydroxygon-4, 9, 11-trien-3-one).

(62) Trenbolone (17{beta}-hydroxyestr-4, 9, 11-trien-3-one).

(63) Any salt, ester or ether of a drug or substance described or listed in this subdivision.

(i) Subdivision (h) of this section shall not include any substance containing anabolic steroids expressly intended for administration through implants to cattle or other nonhuman species and that are approved by the federal food and drug administration solely for such use. Any individual who knowingly and willfully administers to himself or another person, prescribes, dispenses or distributes such substances for other than implantation to cattle or nonhuman species shall be subject to the same penalties as a practitioner who violates the provisions of this section or any other penalties prescribed by law.

Schedule III. (a) Schedule III shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Those compounds, mixtures, or preparations in dosage unit form containing any stimulant substances listed in schedule II which compounds, mixtures, or preparations were listed on August twenty-five, nineteen hundred seventy-one, as excepted compounds under title twenty-one, section 308.32 of the code of federal regulations and any other drug of the quantitative composition shown in that list for those drugs or which is the same except that it contains a lesser quantity of controlled substances.

(2) Benzphetamine.

(3) Chlorphentermine.

(4) Clortermine.

(6) Phendimetrazine.

(c) Depressants. Unless specifically excepted or unless listed in

another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(1) Any compound, mixture or preparation containing:

- (i) Amobarbital;
- (ii) Secobarbital;
- (iii) Pentobarbital;

or any salt thereof and one or more other active medicinal ingredients which are not listed in any schedule.

(2) Any suppository dosage form containing:

- (i) Amobarbital;
- (ii) Secobarbital;
- (iii) Pentobarbital;

or any salt of any of these drugs and approved by the federal food and drug administration for marketing only as a suppository.

(3) Any substance which contains any quantity of a derivative of barbituric acid or any salt thereof.

- (4) Chlorhexadol.
- (5) Lysergic acid.
- (6) Lysergic acid amide.
- (7) Methyprylon.
- (8) Sulfondiethylmethane.
- (9) Sulfonethylmethane.
- (10) Sulfonmethane.

(11) Tiletamine and zolazepam or any salt thereof. Some trade or other names for a tiletamine-zolazepam combination product: Telazol. Some trade or other names for tiletamine: 2-(ethylamino) -2-(2-thienyl) -cyclohexanone. Some trade or other names for zolazepam: 4-(2-fluorophenyl) -6,8-dihydro -1, 3, 8i-trimethylpyrazolo-{3,4-e} {1,4} -diazepin-7(1H)-one, flupyrzapon.

(12) Gamma hydroxybutyric acid, and salt, hydroxybutyric compound, derivative or preparation of gamma hydroxybutyric acid, including any isomers, esters and ethers and salts of isomers, esters and ethers of gamma hydroxybutyric acid, contained in a drug product for which an application has been approved under section 505 of the federal food, drug and cosmetic act.

(13) Ketamine, its salts, isomers and salts of isomers (some other names for ketamine: $(\pm)$ -2-(2-chlorophenyl)-2-(methylamino)-cyclohexanone).

(14) Embutramide.

(d) Nalorphine.

(e) Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below:

(1) Not more than 1.8 grams of codeine per one hundred milliliters or not more than ninety milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

(2) Not more than 1.8 grams of codeine per one hundred milliliters or not more than ninety milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(3) Not more than 1.8 grams of dihydrocodeine per one hundred milliliters or not more than ninety milligrams per dosage unit, with one or more active nonnarcotic ingredients in recognized therapeutic amounts.

(4) Not more than three hundred milligrams of ethylmorphine per one hundred milliliters or not more than fifteen milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(5) Not more than five hundred milligrams of opium per one hundred milliliters or per one hundred grams or not more than twenty-five milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(6) Not more than fifty milligrams of morphine per one hundred milliliters or per one hundred grams, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(7) Buprenorphine in any quantities.

(f) Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved product.

Some other names for dronabinol include: (6aR-trans)-6a, 7, 8, 10a-tetrahydro-6, 6, 9-trimethyl-3-pentyl-6H-dibenzo{b,d} pyran-1-ol, or

(-)-delta-9-(trans) - tetrahydrocannabinol.

(g) Chorionic gonadotropin. (1) Unless specifically excepted or unless listed in another schedule any material, compound, mixture, or preparation which contains any amount of chorionic gonadotropin.

(2) Paragraph one of this subdivision shall not include any substance containing chorionic gonadotropin expressly intended for administration through implants or injection to cattle or other nonhuman species and that are approved by the federal food and drug administration solely for such use. Any individual who knowingly and willfully administers to himself or another person, prescribes, dispenses or distributes such substances for other than implantation or injection to cattle or nonhuman species shall be subject to the same penalties as a practitioner who violates the provisions of this section or any other penalties prescribed by law.

Schedule IV. (a) Schedule IV shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below:

(1) Not more than one milligram of difenoxin and not less than twenty-five micrograms of atropine sulfate per dosage unit.

(2) Dextropropoxyphene (alpha-(+)-4-dimethylamino-1, 2-diphenyl-3-methyl-2-propionoxybutane).

(c) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Alprazolam.

(2) Barbital.

(3) Bromazepam.

(4) Camazepam.

- (5) Chloral betaine.
- (6) Chloral hydrate.
- (7) Chlordiazepoxide.
- (8) Clobazam.
- (9) Clonazepam.
- (10) Clorazepate.
- (11) Clotiazepam.
- (12) Cloxazolam.
- (13) Delorazepam.
- (14) Diazepam.
- (15) Estazolam.
- (16) Ethchlorvynol.
- (17) Ethinamate.
- (18) Ethyl Loflazepate.
- (19) Fludiazepam.
- (20) Flunitrazepam.
- (21) Flurazepam.
- (22) Halazepam.
- (23) Haloxazolam.
- (24) Ketazolam.
- (25) Loprazolam.
- (26) Lorazepam.
- (27) Lormetazepam.
- (28) Mebutamate.
- (29) Medazepam.
- (30) Meprobamate.
- (31) Methohexital.
- (32) Methylphenobarbital (mephobarbital).
- (33) Nimetazepam.
- (34) Nitrazepam.
- (35) Nordiazepam.
- (36) Oxazepam.
- (37) Oxazolam.
- (38) Paraldehyde.
- (39) Petrichoral.
- (40) Phenobarbital.
- (41) Pinazepam.

- (42) Prazepam.
- (43) Temazepam.
- (44) Tetrazepam.
- (45) Triazolam.
- (46) Midazolam.
- (47) Quazepam.
- (48) Zolpidem.
- (49) Dichloralphenazone.
- (50) Zaleplon.
- (51) Zopiclone (eszopiclone).
- (52) Fospropofol.
- (53) Carisoprodol.

* (d) Fenfluramine. Any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers, whenever the existence of such salts, isomers and salts of isomers is possible:

- (1) Fenfluramine.

* NB Repealed upon the removal of fenfluramine and its salts and isomers from Schedule IV of the federal Controlled Substances Act

(e) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of such isomers:

- (1) Cathine ((+) - norpseudoephedrine).
- (2) Diethylpropion.
- (3) Fencamfamin.
- (4) Fenproporex.
- (5) Mazindol.
- (6) Mefenorex.
- (7) Pemoline (including organometallic complexes and chelates thereof).
- (8) Phentermine.
- (9) Pipradrol.
- (10) SPA((-))-1-dimethylamino-1, 2-diphenylethane).
- (11) Modafinil.

(12) Sibutramine.

(f) Other substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts:

(1) Pentazocine.

(2) Butorphanol (including its optical isomers).

(3) Tramadol in any quantities.

Schedule V. (a) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section.

(b) Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by narcotic drugs alone:

(1) Not more than two hundred milligrams of codeine per one hundred milliliters or per one hundred grams.

(2) Not more than one hundred milligrams of dihydrocodeine per one hundred milliliters or per one hundred grams.

(3) Not more than one hundred milligrams of ethylmorphine per one hundred milliliters or per one hundred grams.

(4) Not more than 2.5 milligrams of diphenoxylate and not less than twenty-five micrograms of atropine sulfate per dosage unit.

(5) Not more than one hundred milligrams of opium per one hundred milliliters or per one hundred grams.

(6) Not more than 0.5 milligram of difenoxin and not less than twenty-five micrograms of atropine sulfate per dosage unit.

(c) Stimulants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

(1) Pyrovalerone.

(d) Depressants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(1) Ezogabine {N-{2-amino-4-(4-fluorobenzylamino)-phenyl}-carbamic acid ethyl ester}.

(2) Lacosamide {(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide}.

(3) Pregabalin {(S)-3-(aminomethyl)-5-methylhexanoic acid }.

§ 3307. Exception from schedules. 1. The commissioner may, by regulation, except any compound, mixture, or preparation containing any depressant substance in paragraph (a) of schedule III or in schedule IV from the application of all or any part of this article if (1) the compound, mixture, or preparation contains one or more active medicinal ingredients not having a depressant effect on the central nervous system, and (2) such ingredients are included therein in such combinations, quantity, proportion, or concentration as to vitiate the potential for abuse of the substances which do have a depressant effect on the central nervous system.

2. The commissioner may, by regulation, reclassify as a schedule III substance, any compound, mixture or preparation containing any stimulant substance listed in paragraph (c) of schedule II, if

(a) the compound, mixture or preparation contains one or more active medicinal ingredients not having a stimulant effect on the central nervous system; and

(b) such ingredients are included therein in such combinations, quantity, proportion or concentration as to vitiate the potential for abuse of the substances which do have a stimulant effect on the central nervous system.

3. The commissioner may, by regulation, except any compound, mixture or preparation containing a narcotic antagonist substance from the application of all or any part of this article if (1) such compound, mixture or preparation has no potential for abuse, and (2) such

compound, mixture or preparation has been excepted or exempted from control under the Federal Controlled Substances Act.

4. The commissioner may by regulation exempt or reclassify any compound, mixture or preparation containing any substance listed in subdivision (h) or (j) of Schedule II of section three thousand three hundred six of this article as a Schedule III, IV or V substance if (a) the compound, mixture or preparation contains one or more active medicinal ingredients not found in subdivision (h) or (j) of Schedule II of section three thousand three hundred six of this article; and (b) such ingredients are included therein in such combinations, quantity, proportion or concentration as to substantially reduce the potential for abuse.

5. The commissioner shall by regulation or emergency regulation, reclassify any compound, mixture or preparation containing any substance listed in Schedule I of section three thousand three hundred six of this title as a Schedule II, III, IV or V substance, or exempt it from this article, if that same compound, mixture or preparation is redesignated or rescheduled other than under Schedule I under the federal Controlled Substances Act, or deleted as a controlled substance under the federal Controlled Substances Act. If the commissioner acts under this subdivision and does not exempt the compound, mixture or preparation from this article, he or she may only reclassify it to a newly created subdivision in the same numbered schedule or a higher numbered schedule than to which it is redesignated or rescheduled under the federal act.

6. The commissioner shall establish minimum standards for the storage, reporting, ordering and record keeping of controlled substances specified in subdivision (b-1) of schedule II of section thirty-three hundred six of this article by manufacturers and distributors as if such substances were set forth in schedule III of section thirty-three hundred six of this article.

§ 3308. Powers and duties of the commissioner. 1. The commissioner, and any representative authorized by him, shall have the power to

administer oaths, compel the attendance of witnesses and the production of books, papers and records and to take proof and testimony concerning all matters within the jurisdiction of the department.

2. The commissioner is hereby authorized and empowered to make any rules, regulations and determinations which in his judgment may be necessary or proper to supplement the provisions of this article to effectuate the purposes and intent thereof or to clarify its provisions so as to provide the procedure or details to secure effective and proper enforcement of its provisions.

3. No rule or regulation hereunder shall become effective unless, at least twenty-one days prior to the proposed effective date, persons who have conveyed to the department in writing a request to be notified of proposed changes and additions to the department's rules and regulations under this article have been provided with the text of such proposed rules and regulations and have been given an opportunity to comment in writing thereon.

4. The rules, regulations and determinations, when made and promulgated by the commissioner, shall be the rules, regulations and determinations of the department and, until modified or rescinded, shall have the force and effect of law. It shall be the duty of the department, to enforce all of the provisions of this article and all of the rules, regulations and determinations made thereunder.

5. Notwithstanding any inconsistent provision of this article, the commissioner in consultation with the commissioner of education is hereby authorized to promulgate regulations regarding the prescribing, dispensing, use and transmission of electronic prescriptions, which may be prescribed and dispensed in lieu of an official New York state prescription.

6. The commissioner in consultation with the commissioner of education is hereby authorized to promulgate regulations regarding the dispensing of out-of-state prescriptions.

§ 3309. Opioid overdose prevention. 1. The commissioner is authorized to establish standards for approval of any opioid overdose prevention program, and opioid antagonist prescribing, dispensing, distribution, possession and administration pursuant to this section which may include, but not be limited to, standards for program directors, appropriate clinical oversight, training, record keeping and reporting.

2. Notwithstanding any inconsistent provisions of section sixty-five hundred twelve of the education law or any other law, the purchase, acquisition, possession or use of an opioid antagonist pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or this article.

3. (a) As used in this section:

(i) "Opioid antagonist" means a drug approved by the Food and Drug Administration that, when administered, negates or neutralizes in whole or in part the pharmacological effects of an opioid in the body. "Opioid antagonist" shall be limited to naloxone and other medications approved by the department for such purpose.

(ii) "Health care professional" means a person licensed, registered or authorized pursuant to title eight of the education law to prescribe prescription drugs.

(iii) "Pharmacist" means a person licensed or authorized to practice pharmacy pursuant to article one hundred thirty-seven of the education law.

(iv) "Opioid antagonist recipient" or "recipient" means a person at risk of experiencing an opioid-related overdose, or a family member, friend or other person in a position to assist a person experiencing or at risk of experiencing an opioid-related overdose, or an organization registered as an opioid overdose prevention program pursuant to this section or any person or entity or any person employed by the person or entity.

(v) As used in this section, "entity" includes, but is not limited to, a school district, public library, board of cooperative educational services, county vocational education and extension board, charter school, non-public elementary or secondary school, restaurant, bar,

retail store, shopping mall, barber shop, beauty parlor, theater, sporting or event center, inn, hotel or motel.

(vi) "Nightlife establishment" means an establishment that is open to the public for entertainment or leisure, serves alcohol or where alcohol is consumed on the premises, and conducts a large volume of business at night. Such term includes, but is not limited to, bars, entertainment venues, clubs and restaurants.

(b)(i) A health care professional may prescribe by a patient-specific or non-patient-specific prescription, dispense or distribute, directly or indirectly, an opioid antagonist to an opioid antagonist recipient.

(ii) A pharmacist may dispense an opioid antagonist, through a patient-specific or non-patient-specific prescription pursuant to this paragraph, to an opioid antagonist recipient.

(iii) An opioid antagonist recipient may possess an opioid antagonist obtained pursuant to this paragraph, may distribute such opioid antagonist to a recipient, and may administer such opioid antagonist to a person the recipient reasonably believes is experiencing an opioid overdose.

(iv) The provisions of this paragraph shall not be deemed to require a prescription for any opioid antagonist that does not otherwise require a prescription; nor shall it be deemed to limit the authority of a health care professional to prescribe, dispense or distribute, or of a pharmacist to dispense, an opioid antagonist under any other provision of law.

(v) Any pharmacy with twenty or more locations in the state, shall either: (1) pursue or maintain a non-patient-specific prescription with an authorized health care professional to dispense an opioid antagonist to a consumer upon request, as authorized by this section; or (2) register with the department as an opioid overdose prevention program.

3-a. Any distribution of opioid antagonists through this program shall include an informational card or sheet, and fentanyl test strips. The informational card or sheet shall include, at a minimum, information on:

(a) how to recognize symptoms of an opioid overdose;

(b) steps to take prior to and after an opioid antagonist is administered, including calling first responders;

(c) the number for the toll free office of addiction services and

supports' HOPE line;

(d) how to access the office of addiction services and supports' website;

(e) the application of good samaritan protections provided in section three thousand-a of this chapter;

(f) any other information deemed relevant by the commissioner; and

(g) information about fentanyl test strips and their uses.

The educational card shall be provided in languages other than English as deemed appropriate by the commissioner. The department shall make such informational cards available to the opioid overdose prevention programs.

4. (a) Use of an opioid antagonist pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

(b) A recipient, opioid overdose prevention program, person or entity, or any person employed by the person or entity, acting reasonably and in good faith in compliance with this section, shall not be subject to criminal, civil or administrative liability solely by reason of such action.

5. The commissioner shall publish findings on statewide opioid overdose data that reviews overdose death rates and other information to ascertain changes in the cause and rates of opioid overdoses, including fatal opioid overdoses. The report shall be submitted annually, on or before October first, to the governor, the temporary president of the senate, the speaker of the assembly and the chairs of the senate and assembly health committees, and shall be made public on the department's internet website. The report shall include, at a minimum, the following information on a county basis:

(a) information on opioid overdoses and opioid overdose deaths, including age, gender, ethnicity, and geographic location;

(b) data on emergency room utilization for the treatment of opioid overdose;

(c) data on utilization of pre-hospital services;

(d) data on the dispensing and utilization of opioid antagonists; and

(e) any other information necessary to ascertain the success of the program, areas of the state which are experiencing particularly high rates of overdoses, ways to determine if services, resources and responses in particular areas of the state are having a positive impact on reducing overdoses, and ways to further reduce overdoses.

* 6. The commissioner shall provide the current information and data specified by each type of drug included in the report required by subdivision five of this section to each county every three months. The office of addiction services and supports website shall include a hyperlink to such information and data which may be utilized by a county or any combination thereof as it works to address the opioid epidemic.

* NB Repealed March 31, 2027

7. With the first prescription to a particular patient of an opioid of each year for use in a setting other than a general hospital or nursing home under article twenty-eight of this chapter or facility under article thirty-one of the mental hygiene law, or when a practitioner is prescribing a controlled substance to a patient under the care of hospice as defined by section four thousand two of this chapter, the prescriber shall prescribe an opioid antagonist when any of the following risk factors are present: (a) a history of substance use disorder; (b) high dose or cumulative prescriptions that result in ninety morphine milligram equivalents or higher per day; (c) concurrent use of opioids and benzodiazepine or nonbenzodiazepine sedative hypnotics.

8. The commissioner shall establish guidelines for onsite opioid overdose response capacity in nightlife establishments.

9. The commissioner shall, in full accordance with the standards, powers and authorizations established by this section, coordinate with the commissioner of general services to effectuate the duty established by subdivision two-a of section one hundred forty of the public buildings law to equip public institutions and buildings with opioid antagonists.

§ 3309-a. Prescription pain medication awareness program. 1. There is hereby established within the department a prescription pain medication awareness program to educate the public and health care practitioners about the risks associated with prescribing and taking controlled substance pain medications.

2. Within the amounts appropriated, the commissioner, in consultation with the commissioner of the office of alcoholism and substance abuse services, shall develop and conduct a public health education media campaign designed to alert youth, parents and the general population about the risks associated with prescription pain medications and the need to properly dispose of any unused medication. In developing this campaign, the commissioner shall consult with and use information provided by the work group established pursuant to subdivision four of this section and other relevant professional organizations. The campaign shall include an internet website providing information for parents, children and health care professionals on the risks associated with taking opioids and resources available to those needing assistance with prescription pain medication addiction. Such website shall also provide information regarding where individuals may properly dispose of controlled substances in their community and include active links to further information and resources. The campaign shall begin no later than September first, two thousand twelve.

3. Course work or training in pain management, palliative care and addiction. (a) Every person licensed under title eight of the education law to treat humans, registered under the federal controlled substances act and in possession of a registration number from the drug enforcement administration, United States Department of Justice or its successor agency, and every medical resident who is prescribing under a facility registration number from the drug enforcement administration, United States Department of Justice or its successor agency, shall, on or before July first, two thousand seventeen and once within each three year period thereafter, complete three hours of course work or training in pain management, palliative care, and addiction approved by the department.

(b) Every person licensed on or after July first, two thousand

seventeen under title eight of the education law to treat humans, registered under the federal controlled substances act and in possession of a registration number from the drug enforcement administration, United States Department of Justice or its successor agency, and every medical resident who begins prescribing under a facility registration number from the drug enforcement administration, United States Department of Justice or its successor agency on or after July first, two thousand seventeen, shall complete such course work or training within one year of such registration and once within each three year period thereafter.

(c) The commissioner, in consultation with the department of education and the office of alcoholism and substance abuse services, shall establish standards and review and approve course work or training in pain management, palliative care, and addiction and shall publish information related to such standards, course work or training on the department's website.

(d) Existing course work or training, including course work or training developed by a nationally recognized health care professional, specialty, or provider association, or nationally recognized pain management association, may be considered in implementing this subdivision.

(e) Nothing shall preclude course work or training that meets the requirements of paragraph (c) of this subdivision from counting toward this requirement if taken online.

(f) Course work or training shall include, but not be limited to: state and federal requirements for prescribing controlled substances; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening and signs of addiction; responses to abuse and addiction; and end of life care.

(g) Each licensed person required by this subdivision to complete course work or training shall document to the department by attestation on a form prescribed by the commissioner that such licensed person has completed the course work or training required by this subdivision. For medical residents who are prescribing under a facility registration number from the drug enforcement administration, United States Department of Justice or its successor agency, such attestation shall be made by the facility.

(h) The department shall institute a procedure for application for an exemption from said requirement. The department may provide an exemption from the course work and training required by this subdivision to any such licensed person who: (i) clearly demonstrates to the department's satisfaction that there would be no need for him or her to complete such course work or training; or (ii) that he or she has completed course work or training deemed by the department to be equivalent to the course work or training approved by the department pursuant to this subdivision.

(i) Nothing herein shall preclude such course work or training in pain management, palliative care, and addiction from counting toward continuing education requirements under title eight of the education law to the extent provided in the regulations of the commissioner of education.

(j) Nothing herein shall preclude such course work or training in pain management, palliative care, and addiction from counting toward continuing education requirements of a nationally accredited medical board to the extent acceptable to such board.

4. Establish a work group, no later than June first, two thousand twelve, which shall be composed of experts in the fields of palliative and chronic care pain management and addiction medicine. Members of the work group shall receive no compensation for their services, but shall be allowed actual and necessary expenses in the performance of their duties pursuant to this section. The work group shall:

(a) Report to the commissioner regarding the development of recommendations and model courses for continuing medical education, refresher courses and other training materials for licensed health care professionals on appropriate use of prescription pain medication. Such recommendations, model courses and other training materials shall be submitted to the commissioner, who shall make such information available for the use in medical education, residency programs, fellowship programs, and for use in continuing medication education programs no later than January first, two thousand thirteen. Such recommendations also shall include recommendations on: (i) educational and continuing medical education requirements for practitioners appropriate to address prescription pain medication awareness among health care professionals;

(ii) continuing education requirements for pharmacists related to prescription pain medication awareness; and (iii) continuing education in palliative care as it relates to pain management, for which purpose the work group shall consult the New York state palliative care education and training council;

(b) No later than January first, two thousand thirteen, provide outreach and assistance to health care professional organizations to encourage and facilitate continuing medical education training programs for their members regarding appropriate prescribing practices for the best patient care and the risks associated with overprescribing and underprescribing pain medication;

(c) Provide information to the commissioner for use in the development and continued update of the public awareness campaign, including information, resources, and active web links that should be included on the website; and

(d) Consider other issues deemed relevant by the commissioner, including how to protect and promote the access of patients with a legitimate need for controlled substances, particularly medications needed for pain management by oncology patients, and whether and how to encourage or require the use or substitution of opioid drugs that employ tamper-resistance technology as a mechanism for reducing abuse and diversion of opioid drugs.

5. On or before September first, two thousand twelve, the commissioner, in consultation with the commissioner of the office of alcoholism and substance abuse services, the commissioner of education, and the executive secretary of the state board of pharmacy, shall add to the workgroup such additional members as appropriate so that the workgroup may provide guidance in furtherance of the implementation of the I-STOP act. For such purposes, the workgroup shall include but not be limited to consumer advisory organizations, health care practitioners and providers, oncologists, addiction treatment providers, practitioners with experience in pain management, pharmacists and pharmacies, and representatives of law enforcement agencies.

6. The commissioner shall report to the governor, the temporary president of the senate and the speaker of the assembly no later than

March first, two thousand thirteen, and annually thereafter, on the work group's findings. The report shall include information on opioid overdose deaths, emergency room utilization for the treatment of opioid overdose, the utilization of pre-hospital addiction services and recommendations to reduce opioid addiction and the consequences thereof.

§ 3309-b. Dispensing of drug adulterant testing supplies. 1. As used in this section:

* (a) "Drug adulterant testing supplies" means any drug testing product that is used to determine whether a substance contains fentanyl or a fentanyl analog.

* NB Effective until January 16, 2025

* (a) "Drug adulterant testing supplies" means any drug testing product that is used to determine whether a substance contains fentanyl or a fentanyl analog, xylazine, or other substance.

* NB Effective January 16, 2025

(b) "Health care professional" means a person licensed, registered or authorized pursuant to title eight of the education law to prescribe prescription drugs.

(c) "Pharmacist" means a person licensed or authorized to practice pharmacy pursuant to article one hundred thirty-seven of the education law.

2. A health care professional or pharmacist is authorized to dispense drug adulterant testing supplies to any person.

3. Nothing in this section shall be construed to require a license to distribute drug adulterant testing supplies to any person. The commissioner may make all rules and regulations necessary for the implementation of this section.

TITLE II

MANUFACTURE AND DISTRIBUTION OF CONTROLLED SUBSTANCES

Section 3310. Licenses for manufacture or distribution of controlled substances.

- 3311. Authority to issue initial licenses, amended licenses, and to renew licenses.
- 3312. Application for initial license.
- 3313. Granting of initial license.
- 3315. Applications for renewal of licenses to manufacture or distribute controlled substances.
- 3316. Granting of renewal of licenses.
- 3318. Identification of controlled substances.
- 3319. Distribution of free samples.
- 3320. Authorized distribution.
- 3321. Exempt distribution.
- 3322. Reports and records.

§ 3310. Licenses for manufacture or distribution of controlled substances. 1. No person shall manufacture or distribute a controlled substance in this state without first having obtained a license to do so from the department.

2. A license issued under this section shall be valid for two years from the date of issue, except that in order to facilitate the renewals of such licenses, the commissioner may upon the initial application for a license, issue some licenses which may remain valid for a period of time greater than two years but not exceeding an additional eleven months.

3. The fee for a license under this section shall be one thousand two hundred dollars; provided however, if the license is issued for a period greater than two years the fee shall be increased, pro rata, for each additional month of validity.

4. Licenses issued under this section shall be effective only for and shall specify:

- (a) the name and address of the licensee;
- (b) the nature of the controlled substances, either by name or schedule, or both, which may be manufactured or distributed;
- (c) whether manufacture or distribution or both such activities are

permitted by the license.

5. Upon application of a licensee, a license may be amended to allow the licensee to relocate within the state or to add a manufacturing or distributing activity or to add further substances or schedules to the manufacturing or distribution activity permitted thereunder. The fee for such amendment shall be two hundred fifty dollars.

§ 3311. Authority to issue initial licenses, amended licenses, and to renew licenses. 1. Subject to the provisions of this article the commissioner is authorized to issue licenses authorizing the manufacture or distribution of controlled substances.

2. An application for a license, amendment of a license, or renewal of a license which, if granted, would authorize the manufacture or distribution of a controlled substance which the applicant is not then authorized to manufacture or distribute shall, with respect to any such additional authorization, be treated as an application for an initial license.

3. An application for a license which, if granted, would authorize a licensee to continue to manufacture or distribute a controlled substance shall, with respect to such continued manufacture or distribution only, be treated as an application for renewal of a license.

4. A late-filed application for the renewal of a license may, in the discretion of the commissioner, be treated as an application for an initial license.

§ 3312. Application for initial license. 1. An applicant for an initial license to manufacture or distribute controlled substances shall furnish to the department such information as it shall require and evidence that the applicant:

- (a) and its managing officers are of good moral character;
- (b) possesses sufficient land, buildings and equipment to properly

carry on the activity described in the application;

(c) is able to maintain effective control against diversion of the controlled substances for which the license is sought;

(d) is able to comply with all applicable state and federal laws and regulations relating to the manufacture or distribution of the controlled substances for which the license is sought.

2. The application shall include the name, residence address and title of each of the officers and directors and the name and residence address of any person having a ten percentum or greater proprietary, beneficial, equitable or credit interest in the applicant. Each such person, if an individual, or lawful representative if a legal entity, shall submit an affidavit with the application setting forth:

(a) any position of management or ownership during the preceding ten years of a ten percentum or greater interest in any other business, located in or outside this state, manufacturing or distributing drugs; and

(b) whether such person or any such business has been convicted, fined, censured or had a license suspended or revoked in any administrative or judicial proceeding relating to or arising out of the manufacture or distribution of drugs; and

(c) such other information as the commisisoner may require.

3. The applicant shall be under a continuing duty to report to the department any change in facts or circumstances reflected in the application on any newly discovered or occurring fact or circumstance which is required to be included in the application.

§ 3313. Granting of initial license. 1. The commisisoner shall grant an initial license or amendment to a license as to one or more of the substances or activities enumerated in the application if he is satisfied that:

(a) the applicant will be able to maintain effective control against diversion of controlled substances;

(b) the applicant will be able to comply with all applicable state and federal laws;

(c) the applicant and its officers are ready, willing and able to properly carry on the manufacturing or distributing activity for which a license is sought;

(d) the applicant possesses sufficient land, buildings and equipment to properly carry on the activity described in the application;

(e) it is in the public interest that such license be granted; and

(f) the applicant and its managing officers are of good moral character.

2. If the commissioner is not satisfied that the applicant should be issued an initial license, he shall notify the applicant in writing of those factors upon which further evidence is required. Within thirty days of the receipt of such notification, the applicant may submit additional material to the commissioner or demand a hearing or both.

§ 3315. Applications for renewal of licenses to manufacture or distribute controlled substances. 1. An application for the renewal of any license issued pursuant to this title shall be filed with the department not more than six months nor less than four months prior to the expiration thereof.

2. The application for renewal shall include such information prepared in such manner and detail as the commissioner may require, including but not limited to:

(a) any material change in the circumstances or factors listed in section thirty-three hundred twelve of this article;

(b) every known charge or investigation, pending or concluded during the period of the license, by any governmental agency with respect to:

(i) each incident or alleged incident involving the theft, loss, or possible diversion of controlled substances manufactured or distributed by the applicant; and

(ii) compliance by the applicant with the requirements of the federal controlled substances act, or the laws of any state with respect to any substance listed in section thirty-three hundred six of this article.

3. An applicant for renewal shall be under a continuing duty to report

to the department any change in facts or circumstances reflected in the application or any newly discovered or occurring fact or circumstance which is required to be included in the application.

4. If the commissioner is not satisfied that the applicant is entitled to a renewal of such license, he shall within forty-five days after the filing of the application serve upon the applicant or his attorney of record in person or by registered or certified mail an order directing the applicant to show cause why his application for renewal should not be denied. Such order shall specify in detail the respects in which the applicant has not satisfied the commissioner that the license should be renewed.

5. Within thirty days of service of such order, the applicant may either submit additional material to the commissioner or demand a hearing or both. If a hearing is demanded the commissioner shall fix a date for hearing not sooner than fifteen days nor later than thirty days after receipt of the demand, unless such time limitation is waived by the applicant.

§ 3316. Granting of renewal of licenses. 1. The commissioner shall renew a license unless he determines and finds that the applicant:

(a) is unlikely to maintain or be able to maintain effective control against diversion; or

(b) is unlikely to comply with all federal and state laws applicable to the manufacture or distribution of the controlled substance or substances for which the license is sought.

* (c) is unlikely during the period of his or her license to complete the reports or to pay the ratable share required by title two-A of this article on or before the required date. Prior evidence of non-compliance shall constitute substantial evidence of such.

* NB Repealed June 30, 2029

2. For purposes of this section, proof that a licensee, during the period of his license, has failed to maintain effective control against diversion or has knowingly or negligently failed to comply with

applicable federal or state laws relating to the manufacture or distribution of controlled substances, shall constitute substantial evidence that the applicant will be unlikely to maintain effective control against diversion or be unlikely to comply with the applicable federal or state statutes during the period of proposed renewal.

§ 3318. Identification of controlled substances. 1. No controlled substance may be manufactured or delivered within this state in solid or capsule form unless it has clearly marked or imprinted upon each such capsule or solid:

(a) an individual symbol or number assigned to the person who manufactured the controlled substance in such form, and

(b) a code number or symbol assigned by the commissioner identifying such substance or combination of substances.

2. No controlled substance contained within a bottle, vial, carton or other container, or in any way affixed or appended to or enclosed within a package of any kind, and designed or intended for delivery in such container or package to an ultimate consumer, shall be manufactured, delivered or distributed within this state unless such container or package has clearly and permanently marked or imprinted upon it:

(a) an individual symbol or number assigned to the person who packaged the controlled substance in such form; and

(b) a code number or symbol assigned by the commissioner identifying such substance or combination of substances.

3. The commissioner shall assign a code number or symbol to each controlled substance, and in his discretion for combinations of substances, so as to provide ready identification of such substance. Upon application by a manufacturer of controlled substances, the commissioner shall assign to such manufacturer an identifying number or symbol. Wherever possible and practical, the commissioner shall assign code numbers which conform to the national drug code system.

§ 3319. Distribution of free samples. It shall be unlawful to

distribute free samples of controlled substances, except to persons licensed pursuant to title III of this article.

§ 3320. Authorized distribution. 1. Controlled substances may be lawfully distributed within this state only to licensed distributors or manufacturers, practitioners, pharmacists, pharmacies, institutional dispensers, registered outsourcing facilities, and laboratory, research or instructional facilities authorized by law to possess the particular substance distributed.

2. A person authorized to obtain a controlled substance by distribution may lawfully receive such substance only from a distributor licensed pursuant to this article.

§ 3321. Exempt distribution. 1. The commissioner by regulation or ruling may exempt from the licensing requirements of this title:

(a) the return of controlled substances to a manufacturer, registered outsourcing facility or distributor by a practitioner or pharmacy;

(b) the sale of controlled substances by a pharmacy or practitioner to a pharmacy or practitioner for the immediate needs of the pharmacy or practitioner receiving such substances; and

(c) the disposition of controlled substances by a person in lawful possession thereof who, not in the ordinary course of business, wishes to discontinue such possession.

2. Records of such transactions shall be prepared and maintained and reports filed in such manner as the commissioner shall require.

§ 3322. Reports and records. 1. Persons licensed under this title or operating a registered outsourcing facility shall maintain records of all controlled substances manufactured, compounded, received, disposed of, delivered or distributed by them. The record shall show the date of receipt or delivery, the name and address, and registration number of the person from whom received or to whom delivered or distributed, the

kind and quantity of substance received and delivered or distributed, the kind and quantity of substance produced or removed from the process of manufacture and the date thereof.

2. Any person licensed under this title or operating a registered outsourcing facility shall prepare and maintain a biennial report setting forth the current inventory of controlled substances, the quantities of controlled substances manufactured, compounded, delivered or distributed within the state during the period covered by the report and such other information as the commissioner shall by regulation prescribe. Maintaining for inspection a biennial inventory of controlled substances prepared and maintained in compliance with federal statutes and regulations shall be deemed in compliance with this section.

3. Any person licensed under this title or operating a registered outsourcing facility shall forthwith notify the department of any incident involving the theft, loss or possible diversion of controlled substances manufactured, compounded, delivered or distributed by the licensee or operator.

4. The records and reports required by this section shall be prepared, preserved, or filed in such manner and detail as the commissioner shall by regulation prescribe.

* TITLE 2-A

OPIOID STEWARDSHIP ACT

Section 3323. Opioid stewardship fund.

* NB Repealed June 30, 2029

* **§ 3323. Opioid stewardship fund.** 1. Definitions:

(a) "Opioid stewardship payment" shall mean the total amount to be paid into the opioid stewardship fund for each state fiscal year as set forth in subdivision two of this section.

(b) "Ratable share" shall mean the individual portion of the opioid stewardship payment to be paid by each manufacturer and distributor

licensed under this article that sells or distributes opioids in the state of New York.

(c) Notwithstanding any inconsistent provision of law to the contrary, "distribute" shall mean to deliver a controlled substance other than by administering or dispensing to the ultimate user, including intra-company transfers between any division, affiliate, subsidiary, parent or other entity under complete common ownership and control. For purposes of this section, "distribute" shall not include controlled substances surrendered to reverse distributors, or donated to recipient entities or third-party intermediaries pursuant to the unused prescription drug donation and redispensing program of section two hundred eighty-b of this chapter.

2. Opioid stewardship payment imposed on manufacturers and distributors. All manufacturers and distributors licensed under this article (hereinafter referred to as "licensees"), that sell or distribute opioids in the state of New York shall be required to pay an opioid stewardship payment. On an annual basis, the commissioner shall certify to the state comptroller the amount of all revenues collected from opioid stewardship payments and any penalties imposed. The amount of revenues so certified shall be deposited quarterly into the opioid stewardship fund established pursuant to section ninety-seven-aaaaa of the state finance law. No licensee shall pass the cost of their ratable share amount to a purchaser, including the ultimate user of the opioid, or such licensee shall be subject to penalties pursuant to subdivision ten of this section.

3. Determination of opioid stewardship payment. The total opioid stewardship payment amount shall be one hundred million dollars annually, subject to downward adjustments pursuant to subdivision nine of this section.

4. Reports and records. Each manufacturer and distributor licensed under this article that sells or distributes opioids in the state of New York shall provide to the commissioner a report detailing all opioids sold or distributed by such manufacturer or distributor in the state of New York. Such report shall include:

(a) the manufacturer's or distributor's name, address, phone number, federal Drug Enforcement Agency (DEA) registration number and controlled substance license number issued by the department;

(b) the name, address and DEA registration number of the entity to whom the opioid was sold or distributed;

(c) the date of the sale or distribution of the opioid;

(d) the gross receipt total, in dollars, of all opioids sold or distributed;

(e) the name and National Drug Code (NDC) of the opioid sold or distributed;

(f) the number of containers and the strength and metric quantity of controlled substance in each container of the opioid sold or distributed;

(g) the total number of morphine milligram equivalents (MMEs) sold or distributed; and

(h) any other elements as deemed necessary by the commissioner.

4-a. Initial and future reports. (a) Such information shall be reported annually to the department in such form as defined by the commissioner, provided however that the initial report provided pursuant to subdivision four shall consist of all opioids sold or distributed in the state of New York for the two thousand seventeen calendar year, and must be submitted by August 1, 2018. Subsequent annual reports shall be submitted on April first of each year based on the actual opioid sales and distributions of the prior calendar year.

(b) For the purpose of such annual reporting, MMEs shall be determined pursuant to a formulation to be issued by the department and updated as the department deems appropriate.

5. Determination of ratable share. Each manufacturer and distributor licensed under this article that sells or distributes opioids in the state of New York shall pay a portion of the total opioid stewardship payment amount. The ratable share shall be calculated as follows:

(a) The total amount of MMEs sold or distributed in the state of New York by the licensee for the preceding calendar year, as reported by the licensee pursuant to subdivision four of this section, shall be divided by the total amount of MME sold in the state of New York by all

licensees pursuant to this article to determine the licensee payment percentage. The licensee payment percentage shall be multiplied by the total opioid stewardship payment. The product of such calculation shall be the licensee's ratable share. The department shall have the authority to adjust the total number of a licensee's MMEs to account for the nature and use of the product, as well as the type of entity purchasing the product from the licensee, when making such determination and adjust the ratable share accordingly.

(b) The licensee's total amount of MME sold or distributed, as well as the total amount of MME sold or distributed by all licensees under this article, used in the calculation of the ratable share shall not include the MME of those opioids which are: (i) manufactured in New York state, but whose final point of delivery or sale is outside of New York state; (ii) sold or distributed to entities certified to operate pursuant to article thirty-two of the mental hygiene law, or article forty of the public health law; or (iii) the MMEs attributable to buprenorphine, methadone or morphine.

(c) The department shall provide to the licensee, in writing, on or before October fifteenth, two thousand eighteen, the licensee's ratable share for the two thousand seventeen calendar year. Thereafter, the department shall notify the licensee in writing annually on or before October fifteenth of each year based on the opioids sold or distributed for the prior calendar year.

6. Payment of ratable share. The licensee shall make payments quarterly to the department with the first payment of the ratable share, provided that the amount due on January first, two thousand nineteen shall be for the full amount of the first annual payment, with additional payments to be due and owing on the first day of every quarter thereafter.

7. Rebate of ratable share. In any year for which the commissioner determines that a licensee failed to report required information as required by this section, those licensees complying with this section shall receive a reduced assessment of their ratable share in the following year equal to the amount in excess of any overpayment in the prior payment period.

8. Licensee opportunity to appeal. A licensee shall be afforded an opportunity to submit information to the department to justify why the ratable share provided to the licensee, pursuant to paragraph (c) of subdivision five of this section, or amounts paid thereunder are in error or otherwise not warranted. If the department determines thereafter that all or a portion of such ratable share, as determined by the commissioner pursuant to subdivision five of this section, is not warranted, the department may: (a) adjust the ratable share; (b) adjust the assessment of the ratable share in the following year equal to the amount in excess of any overpayment in the prior payment period; or (c) refund amounts paid in error.

9. Department annual review. The department shall annually review the amount of state operating funds spent in the office of alcoholism and substance abuse services (OASAS) budget for opioid prevention, treatment and recovery. The commissioner of OASAS shall certify to the department the amount of annual spending for such services, utilizing available information on patient demographics and the actual cost of services delivered by the state and by state-funded providers. The certification of such spending shall begin in state fiscal year two thousand eighteen-nineteen, and continue annually thereafter. The total amount of such spending shall be provided to the department by the commissioner of OASAS no later than June thirtieth of each year. There shall be no stewardship fund payments beginning on July first in the event state operating funds spent in the OASAS budget for opioid prevention, treatment and recovery in the most recently reported year is equal to or less than state operating funds spent for such purposes in state fiscal year two thousand nine-ten.

10. Penalties. (a) The department may assess a civil penalty in an amount not to exceed one thousand dollars per day against any licensee that fails to comply with subdivisions four and four-a of this section.

(b) In addition to any other civil or criminal penalty provided by law, where a licensee has failed to pay its ratable share in accordance with subdivision six of this section, the department may also assess a penalty of no less than ten percent and no greater than three hundred

percent of the ratable share due from such licensee.

(c) Where the ratable share, or any portion thereof, has been passed on to a purchaser by a licensee, the commissioner may impose a penalty not to exceed one million dollars per incident.

* NB Repealed June 30, 2029

TITLE III

RESEARCH, INSTRUCTIONAL ACTIVITIES, AND CHEMICAL ANALYSIS RELATING TO CONTROLLED SUBSTANCES

Section 3324. Licenses to engage in research, instructional activities, and chemical analysis relating to controlled substances.

3325. Authority to issue licenses; applications.

3326. Institutional research licenses.

3327. Procedure.

3328. Exemptions from title.

3329. Reports and records.

§ 3324. Licenses to engage in research, instructional activities, and chemical analysis relating to controlled substances. 1. No person within this state shall manufacture, obtain, possess, administer or dispense a controlled substance for purposes of scientific research, instruction or chemical analysis without having first obtained a license to do so from the department.

2. A license issued under this title shall be valid for two years from the date of issue.

3. The fee for a license under this title shall be forty dollars.

4. Licenses issued under this title shall be effective only for and shall specify:

(a) the name and address of the licensee;

(b) the nature of the project or projects permitted by the license;

(c) the nature of the controlled substance or substances to be used in the project, by name if in schedule I, and by name or schedule or both

if in any other schedule;

(d) whether dispensing to human subjects is permitted by the license.

5. Upon application of a person licensed pursuant to this title, a license may be amended to add a further activity or to add further substances or schedules to the project permitted thereunder. The fee for such amendment shall be twenty dollars.

§ 3325. Authority to issue licenses; applications. 1. Subject to the provisions of this title, the commissioner is authorized to license a person to manufacture, obtain and possess, dispense, and administer controlled substances for purposes of scientific research, chemical analysis or instruction.

2. A license or amendment of a license shall be issued by the department unless the applicant therefor has failed to furnish a satisfactory protocol pursuant to subdivision three of this section, or a satisfactory statement pursuant to section 3326, and proof that the applicant:

(a) and its managing officers are of good moral character;

(b) possesses or is capable of acquiring facilities, staff and equipment sufficient to carry on properly the proposed project detailed in the protocol or statement accompanying the application;

(c) is able to maintain effective control against diversion of the controlled substances for which the license is sought;

(d) is able to comply with all applicable state and federal laws and regulations relating to the controlled substances for which the license is sought.

3. An application for a license or for an amendment to a license shall be accompanied by a detailed protocol setting forth:

(a) the nature of the proposed project;

(b) the proposed quantity or quantities of each controlled substance involved;

(c) the qualifications and competence of the applicant to engage in such project;

(d) specific provisions for the safe administration or dispensing of controlled substances to humans, if such is contemplated, and the proposed method of selecting humans;

(e) such other additional information as the commissioner may require.

4. The application for a license pursuant to this title shall include copies of all papers filed with the Bureau, the Federal Food and Drug Administration and any other governmental agency, whether state or federal, in connection with the applicant's proposed project.

§ 3326. Institutional research licenses. 1. Subject to the provisions of this title, the commissioner is authorized to license an institution, which regularly engages in research, to approve specific projects conducted under its immediate auspices.

2. An institution seeking a license pursuant to this section shall make application in the same manner as an applicant for a license pursuant to section 3325. However, such institution shall submit, in lieu of a detailed protocol of a specific project, a statement including:

(a) the qualifications and such other data as the commissioner may require regarding each member of the committee within the institution which will approve specific projects;

(b) a description of the system within the institution for approving, supervising and evaluating such projects.

3. Upon approval of each specific project, such institution shall forward to the commissioner a description of the project, the names and qualifications of the individuals working thereon and of those individuals designated to supervise the project. If administration or dispensing to human subjects is contemplated, there shall also be included a description of the provisions for safe administration or dispensing.

4. Such institution shall forward to the commissioner periodic progress reports and evaluations of, as well as amendments to each

project, in such manner and in such detail as the commissioner may prescribe.

§ 3327. Procedure. 1. A license or amendment to a license shall be issued or refused by the department within ninety days from the date of filing of a completed application.

2. Within thirty days of notification of such refusal, the applicant may either submit additional material to the commissioner or demand a hearing or both. If a hearing is demanded the commissioner shall fix a date for hearing not sooner than fifteen days nor later than thirty days after receipt of the demand, unless such time limitation is waived by the applicant.

§ 3328. Exemptions from title. The following persons engaging in the following activities shall be exempt from the provisions of this title:

1. A practitioner lawfully administering, dispensing, or prescribing a controlled substance in the course of his professional practice to an ultimate user for a recognized medical purpose;

2. A licensed manufacturer engaged in research upon non-human subjects or chemical analysis conducted on the premises specified in the manufacturer's license;

3. A licensed distributor engaged in quality control analysis at the premises specified in his license.

4. A practitioner or patient participating in a clinical research program on the therapeutic use of marijuana or tetrahydrocannabinols. (a) Each such clinical research program shall have received protocol approval from the United States Food and Drug Administration, shall possess an effective investigational new drug application and shall have been registered by the Drug Enforcement Administration, United States Department of Justice.

(b) Each such clinical research program authorized under the provisions of article thirty-three-A of this chapter.

§ 3329. Reports and records. 1. Persons licensed under this title shall keep records showing the receipt, administration, dispensing, or destruction of all controlled substances and maintain the records in such manner and detail as the commissioner, by regulation, shall require.

2. Persons licensed under this title shall submit reports to the department summarizing the activity conducted under the license. Included in such report shall be a detailed inventory of controlled substances, and an accounting for all such substances received or disposed of during the period covered by the report and such other information as the commissioner shall, by regulation, require. Such reports shall be filed with the department at such times as the commissioner may require.

TITLE IV

DISPENSING TO ULTIMATE USERS

- Section 3330. Schedule I substances.
3331. Scheduled substances administering and dispensing by practitioners.
3332. Making of official New York state prescriptions or electronic prescriptions for scheduled substances.
3333. Dispensing upon official New York state prescription or electronic prescription.
3334. Emergency oral prescriptions for schedule II drugs and certain other controlled substances.
3335. Dispensing by online dispensers of controlled substances.
3337. Oral prescriptions schedule III, IV and V substances.
3338. Official New York state prescription forms.
3339. Refilling of prescriptions for controlled substances.
3341. Institutional dispensers certificates of approval.

- 3342. Dispensing and administering by institutional dispensers.
- 3343. Reports and records.
- 3343-a. Prescription monitoring program registry.
- 3343-b. Safe disposal of unused controlled substances.
- 3345. Possession of controlled substances by ultimate users original containers.

§ 3330. Schedule I substances. No prescription may be made or filled for any controlled substance in schedule I nor may such substance be possessed, distributed, dispensed or administered except pursuant to title III of this article.

§ 3331. Scheduled substances administering and dispensing by practitioners. 1. Except as provided in titles III or V of this article, no substance in schedules II, III, IV, or V may be prescribed for or dispensed or administered to a person with substance use disorder or habitual user.

2. A practitioner, in good faith, and in the course of his or her professional practice only, may prescribe, administer and dispense substances listed in schedules II, III, IV, and V, or he or she may cause the same to be administered by a designated agent under his or her direction and supervision.

3. A veterinarian, in good faith, and in the course of the practice of veterinary medicine only, may prescribe, administer and dispense substances listed in schedules II, III, IV, and V or he may cause them to be administered by a designated agent under his direction and supervision.

4. No such substance may be dispensed unless it is enclosed within a suitable and durable container, and:

(a) Affixed to such container is a label upon which is indelibly typed, printed or otherwise legibly written the following:

(i) the name and address of the ultimate user for whom the substance is intended, or, if intended for use upon an animal, the species of such animal and the name and address of the owner or person in custody of such animal;

(ii) the name, address, and telephone number of the dispensing practitioner;

(iii) specific directions for use, including but not limited to the dosage and frequency of dosage, and the maximum daily dosage;

(iv) the legend, prominently marked or printed in either boldface or upper case lettering: "CONTROLLED SUBSTANCE, DANGEROUS UNLESS USED AS DIRECTED";

(v) the date of dispensing;

(vi) either the name of the substance or such code number assigned by the department for the particular substance pursuant to section thirty-three hundred eighteen of this article;

(b) Such container shall be identified as a controlled substance by either:

(i) an orange label;

(ii) a label of another color over which is superimposed an orange transparent adhesive tape; or

(iii) an auxiliary orange label affixed to the front of such container and bearing the legend, prominently marked or printed "Controlled Substance, Dangerous Unless Used As Directed";

(c) Any label, transparency, or auxiliary label shall be applied in a manner which would inhibit its removal.

5. (a) No more than a thirty day supply or, pursuant to regulations of the commissioner enumerating conditions warranting specified greater supplies, no more than a three month supply of a schedule II, III or IV substance, as determined by the directed dosage and frequency of dosage, may be dispensed by an authorized practitioner at one time.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, a practitioner, within the scope of his or her professional opinion or discretion, may not prescribe more than a seven-day supply of any schedule II, III, or IV opioid to an ultimate user upon the initial consultation or treatment of such user for acute pain. Upon any subsequent consultations for the same pain, the practitioner may issue,

in accordance with paragraph (a) of this subdivision, any appropriate renewal, refill, or new prescription for the opioid or any other drug.

(c) For the purposes of this subdivision, "acute pain" shall mean pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the practitioner reasonably expects to last only a short period of time. Such term shall not include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life care, or pain being treated as part of palliative care practices.

6. A practitioner dispensing a controlled substance shall file information pursuant to such dispensing with the department by electronic means in such manner and detail as the commissioner shall, by regulation, require. This requirement shall not apply to the dispensing by a practitioner pursuant to subdivision six of section thirty-three hundred fifty-one of this article.

7. A practitioner may not administer, prescribe or dispense any substance referred to in subdivision (h) of Schedule II, and subdivision (g) of Schedule III, of section three thousand three hundred six of this article for other than therapeutic purposes. A practitioner may not administer, prescribe or dispense any such substance to any individual without first obtaining the informed consent of such individual, or where the individual lacks capacity to give such consent, a person legally authorized to consent on his or her behalf.

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

9. (a) When a patient seeks treatment for any neuromusculoskeletal condition that causes pain, where a practitioner considers an opioid

treatment, the practitioner shall consider, discuss with the patient, and, as appropriate, refer or prescribe non-opioid treatment alternatives, based on the practitioner's clinical judgment and following generally accepted national professional or treatment guidelines, and consistent with patient preference and consent, before starting a patient on opioid treatment. For the purposes of this subdivision, non-opioid treatment alternatives include, but are not limited to: acupuncture, chiropractic, massage therapy, physical therapy, occupational therapy, cognitive behavioral therapy, non-opioid medications, interventional treatments and non-clinical activities such as exercise. The practitioner shall inform the patient that some treatments may not be covered by the patient's health coverage.

(b) The requirements of this subdivision shall not apply for patients being treated under any of the following circumstances: treatment of cancer; hospice or other end-of-life care; post-surgery treatment immediately following a surgical procedure; or in a medical emergency. For purposes of this subdivision, "medical emergency" means an acute injury or illness that poses an immediate risk to a person's life or health.

§ 3332. Making of official New York state prescriptions or electronic prescriptions for scheduled substances. 1. No controlled substance may be prescribed by a practitioner except on an official New York state prescription or on an electronic prescription, and in good faith and in the course of his or her professional practice only.

2. Such prescription shall be prepared on an official New York state prescription form, written with ink, indelible pencil or, apart from the practitioner's signature, typewriter or electronic printer, or to the extent authorized by federal requirements, on an electronic prescription. The original official New York state prescription or the electronic prescription must contain the following:

(a) the name, address, and age of the ultimate user for whom the substance is intended, or, if the ultimate user is an animal, the species of such animal and the name and address of the owner or person having custody of such animal;

(b) the name, address, Federal registration number, telephone number, and handwritten signature of the prescribing practitioner, except that an electronic prescription must contain the electronic signature of the prescribing practitioner;

(c) specific directions for use, including but not limited to the dosage and frequency of dosage and the maximum daily dosage;

(d) the date upon which such prescription was actually signed by the prescribing practitioner.

3. No such prescription shall be made for a quantity of controlled substances which would exceed a thirty day supply if the controlled substance were used in accordance with the directions for use specified on the prescription. A practitioner may, however, issue a prescription for up to a three month supply of a controlled substance provided that the controlled substance has been prescribed to treat one of the conditions that have been enumerated by the commissioner pursuant to regulations as warranting the prescribing of greater than a thirty day supply of a controlled substance and that the practitioner specifies the condition on the face of the prescription. No additional prescriptions for a controlled substance may be issued by a practitioner to an ultimate user within thirty days of the date of any prescription previously issued unless and until the ultimate user has exhausted all but a seven day supply of the controlled substance provided by any previously issued prescription. A practitioner may, however, issue a prescription for up to a six month supply of any substance listed in subdivision (h) of Schedule II of section thirty-three hundred six of this article provided that such substance has been prescribed to treat one of the conditions that have been enumerated by the commissioner pursuant to regulations as warranting the prescribing of a six month supply and that the practitioner specifies the condition on the prescription or on the electronic prescription.

4. The practitioner shall deliver the original official New York state prescription to the ultimate user or shall transmit the electronic prescription to the pharmacy.

§ 3333. Dispensing upon official New York state prescription or electronic prescription. 1. A licensed pharmacist may, in good faith and in the course of his or her professional practice, sell and dispense to an ultimate user controlled substances only upon the delivery of an official New York state prescription or the receipt of an electronic prescription to such pharmacist, within thirty days of the date such prescription was signed by an authorized practitioner; provided, however, a pharmacist may dispense a part or portion of such prescription in accordance with regulations of the commissioner in consultation with the commissioner of education. No pharmacy or pharmacist may sell or dispense greater than a thirty day supply of a controlled substance to an ultimate user unless and until the ultimate user has exhausted all but a seven day supply of the controlled substance provided pursuant to any previously issued prescription, except that a pharmacy or pharmacist may sell or dispense up to a three month supply of a controlled substance if there appears, on the official New York state prescription or electronic prescription, a statement that the controlled substance has been prescribed to treat one of the conditions that have been enumerated by the regulations of the commissioner as warranting the prescribing of greater than a thirty day supply of a controlled substance. A pharmacy or pharmacist may sell or dispense up to a six month supply of any substance listed in subdivision (h) of Schedule II of section thirty-three hundred six of this article if there appears, on the official New York state prescription or on an electronic prescription, a statement that the substance has been prescribed to treat one of the conditions that have been enumerated by the regulations of the commissioner as warranting the prescribing of a specified greater supply.

2. No controlled substance may be so dispensed or sold unless it is enclosed within a suitable container, and:

(a) Affixed to such container is a label upon which is indelibly typed, printed, or otherwise legibly written the following:

(i) the name and address of the ultimate user for whom the substance is intended, or if intended for use upon an animal, the species of such animal and the name and address of the owner or person in custody of such animal;

(ii) the name, address, and telephone number of the pharmacy from which such substance is dispensed;

(iii) specific directions for use as stated on the prescription;

(iv) the name of the prescribing practitioner;

(v) the legend, prominently marked or printed in either boldface or upper case lettering: "CONTROLLED SUBSTANCE, DANGEROUS UNLESS USED AS DIRECTED";

(vi) the number of the prescription under which it is recorded in the pharmacist's prescription file;

(vii) such code number assigned by the department for the particular substance pursuant to section thirty-three hundred eighteen of this article, or when requested by the practitioner, the name of such substance;

(b) Such container shall be identified as a controlled substance by either:

(i) an orange label;

(ii) a label of another color over which is superimposed an orange transparent adhesive tape; or

(iii) an auxiliary orange label affixed to the front of such container and bearing the legend, prominently marked or printed "Controlled Substance, Dangerous Unless Used As Directed";

(c) Any label, transparency, or auxiliary label shall be applied in a manner which would inhibit its removal.

3. The pharmacist filling the controlled substance prescription shall endorse upon the original official New York state prescription the date of delivery and his or her signature or, if an electronic prescription, his or her electronic signature.

4. The endorsed original prescription shall be retained by the proprietor of the pharmacy for a period of five years. The proprietor of the pharmacy shall file or cause to be filed such prescription information with the department by electronic means on a real time basis as the commissioner in consultation with the commissioner of education shall, by regulation, require; provided, however, that the commissioner may, pursuant to a process established in regulation, grant a waiver allowing a pharmacy to make such filings within a longer period of time

if and to the extent that the commissioner finds it warranted, in his or her discretion, due to economic hardship, technological limitations that are not reasonably within the control of the pharmacy, or other exceptional circumstance demonstrated by the pharmacy; and provided, further, however, that such regulations shall specify the manner in which such requirements shall apply to the delivery of controlled substances to individuals in this state by means of mail or licensed express delivery services.

5. When filing prescription information electronically pursuant to subdivision four of this section, the proprietor of the pharmacy shall dispose of any electronically recorded prescription information in such manner as the commissioner shall by regulation require.

§ 3334. Emergency oral prescriptions for schedule II drugs and certain other controlled substances. 1. In an emergency situation, as defined by rule or regulation of the department, a practitioner may orally prescribe and a pharmacist may dispense to an ultimate user controlled substances in schedule II and those schedule III or schedule IV controlled substances as the commissioner may, by regulation, require; provided however the pharmacist shall:

(a) contemporaneously reduce such prescription to writing or to the extent authorized by federal requirements, to an electronic record;

(b) dispense the substance in conformity with the labeling requirements applicable to the type of prescription which would be required but for the emergency; and

(c) make a good faith effort to verify the practitioner's identity, if the practitioner is unknown to the pharmacist.

2. No oral prescription shall be filled for a quantity of controlled substances which would exceed a five day supply if the substance were used in accordance with the directions for use.

3. Within seventy-two hours after authorizing an emergency oral prescription, the prescribing practitioner shall cause to be delivered to the pharmacist the original of an official New York state

prescription or an electronic prescription. Such prescription shall, in addition to the information otherwise required, also have upon the official New York state prescription or upon the electronic prescription the words: "Authorization for emergency dispensing." If the pharmacist fails to receive such prescription he or she shall notify the department in writing or electronically within seven days from the date of dispensing the substance.

4. Such official New York state prescription or electronic prescription shall be endorsed, and retained and filed in the same manner as is otherwise required for such prescriptions.

§ 3335. Dispensing by online dispensers of controlled substances. A controlled substance may be sold, delivered, or dispensed by means of the internet but only in accordance with this article. An online dispenser shall file with the department by electronic means information concerning the dispensing by means of the internet, of any controlled substances in such manner as the commissioner by regulation shall require.

§ 3337. Oral prescriptions schedule III, IV and V substances. 1. Except as provided in section thirty-three hundred thirty-four of this title, a practitioner may orally prescribe and a pharmacist may dispense to an ultimate user controlled substances in schedules III, IV or V provided however the pharmacist shall:

(a) contemporaneously reduce such prescription to writing or, to the extent authorized by federal requirements, an electronic record;

(b) dispense the substance in conformity with the labeling requirements applicable to a prescription; and

(c) make a good faith effort to verify the practitioner's identity, if the practitioner is unknown to the pharmacist.

2. No oral prescription shall be filled for a quantity of controlled substances which would exceed a five day supply if the controlled substance were used in accordance with the directions for use, except

that with respect to a schedule IV substance such prescription shall not exceed a thirty-day supply or one hundred dosage units, whichever is less; provided, however, that this provision shall not apply to any schedule IV controlled substance limited to a five day supply by section thirty-three hundred thirty-four of this title.

3. Within seventy-two hours after authorizing such an oral prescription, the prescribing practitioner shall cause to be delivered to the pharmacist an official New York state prescription or an electronic prescription. If the pharmacist fails to receive such prescription he or she shall make a record of such fact in such manner and detail as the commissioner in consultation with the commissioner of education, by regulation, shall require.

4. Such official New York state prescription or electronic prescription shall be endorsed, retained and filed in the same manner as is otherwise required for such prescriptions.

§ 3338. Official New York state prescription forms. 1. Official New York state prescription forms shall be prepared and issued by the department in the manner and detail as the commissioner in consultation with the commissioner of education may, by regulation, require, and, each form shall be serialized. Such forms shall be furnished to practitioners authorized to write such prescriptions and to institutional dispensers. Such prescription blanks shall not be transferable.

2. Except as expressly authorized by section thirty-three hundred thirty-four or thirty-three hundred thirty-seven of this article, controlled substances may be prescribed or dispensed only upon an official New York state prescription or, pursuant to regulations, an electronic prescription or out-of-state prescription.

3. The commissioner in consultation with the commissioner of education is hereby authorized and empowered to make rules and regulations, not inconsistent with this article, with respect to the retention or filing

of such official New York state prescription forms, electronic prescriptions and out-of-state prescriptions, including information required to be filed with the department, the maximum number of official prescription forms which may be issued at any one time, the manner in which such forms shall be issued, the period of time after issuance by the department that such form shall remain valid for use, and the manner in which practitioners associated with institutional dispensers may use such forms, or any other matter of procedure or detail necessary to effectuate or clarify the provisions of this section and to secure proper and effective enforcement of the provisions of this article.

4. Upon a finding by the commissioner that a person has willfully failed to comply with the provisions of this article, the commissioner may revoke, cancel or withhold official New York state prescription forms which have been issued or for which application has been made.

§ 3339. Refilling of prescriptions for controlled substances. 1.

Prescriptions for a schedule II controlled substance and those schedule III or schedule IV controlled substances which the commissioner may require by regulation may not be refilled.

2. A prescription, except for a schedule II controlled substance or those schedule III or schedule IV controlled substances which the commissioner may require by regulation may be refilled not more than the number of times specifically authorized by the prescriber upon the prescription, provided however no such authorization shall be effective for a period greater than six months from the date the prescription is signed. In the event that the prescription authorizes the dispensing of more than a thirty day supply of schedule III, schedule IV or schedule V substances pursuant to regulations of the commissioner enumerating conditions warranting specified greater supplies, the prescription may be refilled only once.

3. Unless an earlier refilling is authorized by the prescriber, no prescription for a controlled substance may be refilled earlier than seven days prior to the date the previously dispensed supply would be

exhausted if used in conformity with the directions for use.

§ 3341. Institutional dispensers certificates of approval. 1. No institutional dispenser as herein before defined, shall receive, possess or cause controlled substances to be administered or dispensed without first having been issued a certificate of approval authorizing such activity by the commissioner.

2. Upon application of an institutional dispenser for a certificate of approval, the commissioner shall issue such certificate if he is satisfied that:

(a) the applicant and its managing officers are of good moral character;

(b) the applicant possesses the necessary land, building, paraphernalia and staff to properly carry on the activities described in the application;

(c) the applicant will be able to maintain effective control against diversion of controlled substances; and

(d) the applicant will be able to comply with all applicable state and federal laws.

3. Institutional dispensers to whom such certificates have been issued shall thereafter register biennially with the department. The fee for such certificate and for each biennial registration shall be one hundred dollars.

4. Certificates and registrations issued under this section shall be effective only for and shall specify:

(a) the name and address of the institutional dispenser;

(b) the nature of the controlled substance, or substances, either by name or schedule, or both, for which the certificate or registration is issued.

§ 3342. Dispensing and administering by institutional dispensers. 1. An institutional dispenser may cause controlled substances to be

administered or dispensed for use on its premises or for the immediate care or treatment of a patient lawfully being transferred in an emergency situation, as defined by rule or regulation of the commissioner, to an alternative medical facility only pursuant to a written order by a practitioner for medication. Such orders shall be made and preserved in the manner and form as the commissioner shall, by regulation, prescribe.

2. An institutional dispenser may dispense controlled substances for use off its premises only pursuant to a prescription, prepared and filed in conformity with this title, provided, however, that, in an emergency situation as defined by rule or regulation of the department, a practitioner in a hospital without a full-time pharmacy may dispense controlled substances to a patient in a hospital emergency room for use off the premises of the institutional dispenser for a period not to exceed twenty-four hours.

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

3. An institutional dispenser shall maintain records of all controlled substances dispensed and administered in such manner as the commissioner shall, by regulation, require.

§ 3343. Reports and records. 1. Prescriptions and copies of prescriptions shall be preserved in the following manner:

(a) dispensing practitioners filing information electronically pursuant to subdivision six of section thirty-three hundred thirty-one of this article, shall dispose of any electronically recorded information in such manner as the commissioner in consultation with the commissioner of education shall by regulation require;

(b) pharmacists dispensing controlled substances upon prescription shall preserve such prescriptions in such manner as the commissioner in

consultation with the commissioner of education shall, by regulation, require.

2. Practitioners and pharmacies shall maintain records of all controlled substances received and dispensed in such manner as the commissioner shall, by regulation, require.

§ 3343-a. Prescription monitoring program registry. 1. Establishment of system. (a) The commissioner shall, in accordance with the provisions of this section, establish and maintain an electronic system for collecting, monitoring and reporting information concerning the prescribing and dispensing of controlled substances, to be known as the prescription monitoring program registry. The registry shall include information reported by pharmacies on a real time basis, as set forth in subdivision four of section thirty-three hundred thirty-three of this article.

(b) The registry shall include, for each person to whom a prescription for controlled substances has been dispensed, all patient-specific information covering such period of time as is deemed appropriate and feasible by the commissioner, but no less than six months and no more than five years. Such patient-specific information shall be obtained from the prescription information reported by pharmacies pursuant to subdivision four of section thirty-three hundred thirty-three of this article and by practitioners who dispense pursuant to subdivision six of section thirty-three hundred thirty-one of this article, and shall be processed and included in the registry by the department without undue delay. For purposes of this article, "patient-specific information" means information pertaining to individual patients included in the registry, which shall include the following information and such other information as is required by the department in regulation:

- (i) the patient's name;
- (ii) the patient's residential address;
- (iii) the patient's date of birth;
- (iv) the patient's gender;
- (v) the date on which the prescription was issued;
- (vi) the date on which the controlled substance was dispensed;

(vii) the metric quantity of the controlled substance dispensed;
(viii) the number of days supply of the controlled substance dispensed;

(ix) the name of the prescriber;

(x) the prescriber's identification number, as assigned by the drug enforcement administration;

(xi) the name or identifier of the drug that was dispensed; and

(xii) the payment method.

(c) The registry shall be secure, easily accessible by practitioners and pharmacists, and compatible with the electronic transmission of prescriptions for controlled substances, as required by section two hundred eighty-one of this chapter, and section sixty-eight hundred ten of the education law, and any regulations promulgated pursuant thereto. To the extent practicable, implementation of the electronic transmission of prescriptions for controlled substances shall serve to streamline consultation of the registry by practitioners and reporting of prescription information by pharmacists. The registry shall be interoperable with other similar registries operated by federal or state governments, to the extent deemed appropriate by the commissioner, and subject to the provisions of section thirty-three hundred seventy-one-a of this article.

(d) The department shall establish and implement such protocols as are reasonably necessary to ensure that information contained in the registry is maintained in a secure and confidential manner and is accessible only by practitioners, pharmacists or their designees for the purposes established in subdivisions two and three of this section, or as otherwise set forth in sections thirty-three hundred seventy-one and thirty-three hundred seventy-one-a of this article. Such protocols shall include a mechanism for the department to monitor and record access to the registry, which shall identify the authorized individual accessing and each controlled substance history accessed.

2. Duty to consult prescription monitoring program registry; practitioners. (a) Every practitioner shall consult the prescription monitoring program registry prior to prescribing or dispensing any controlled substance listed on schedule II, III or IV of section thirty-three hundred six of this article, for the purpose of reviewing a

patient's controlled substance history as set forth in such registry; provided, however, that nothing in this section shall preclude an authorized practitioner, other than a veterinarian, from consulting the registry at his or her option prior to prescribing or dispensing any controlled substance. The duty to consult the registry shall not apply to:

- (i) veterinarians;

- (ii) a practitioner dispensing pursuant to subdivision four of section thirty-three hundred fifty-one of this article;

- (iii) a practitioner administering a controlled substance;

- (iv) a practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser pursuant to section thirty-three hundred forty-two of this title;

- (v) a practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

- (vi) a practitioner prescribing a controlled substance to a patient under the care of a hospice, as defined by section four thousand two of this chapter;

- (vii) a practitioner when:

- (A) it is not reasonably possible for the practitioner to access the registry in a timely manner;

- (B) no other practitioner or designee authorized to access the registry, pursuant to paragraph (b) of this subdivision, is reasonably available; and

- (C) the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

- (viii) a practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient;

- (ix) a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due

to a temporary technological or electrical failure, as set forth in regulation; or

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

(b) For purposes of this section, a practitioner may authorize a designee to consult the prescription monitoring program registry on his or her behalf, provided that: (i) the designee so authorized is employed by the same professional practice or is under contract with such practice; (ii) the practitioner takes reasonable steps to ensure that such designee is sufficiently competent in the use of the registry; (iii) the practitioner remains responsible for ensuring that access to the registry by the designee is limited to authorized purposes and occurs in a manner that protects the confidentiality of the information obtained from the registry, and remains responsible for any breach of confidentiality; and (iv) the ultimate decision as to whether or not to prescribe or dispense a controlled substance remains with the practitioner and is reasonably informed by the relevant controlled substance history information obtained from the registry. The commissioner shall establish in regulation reasonable parameters with regard to a practitioner's ability to authorize designees pursuant to this section, which shall include processes necessary to allow the department to: (A) grant access to the registry in a reasonably prompt manner to as many designees as are authorized by practitioners, up to the number deemed appropriate by the commissioner for particular professional practices or types of practices, taking into account the need to maintain security of the registry and the patient-specific information maintained therein, and the objective of minimizing burdens to practitioners to the extent practicable; (B) require that practitioners notify the department upon terminating the authorization of any designee; and (C) establish a mechanism to prevent such terminated designees from accessing the registry in a reasonably prompt manner following such notification.

3. Authority to consult prescription monitoring program registry;

pharmacists. (a) A pharmacist may consult the prescription monitoring program registry in order to review the controlled substance history of an individual for whom one or more prescriptions for controlled substances is presented to such pharmacist.

(b) For purposes of this section, a pharmacist may designate another pharmacist, a pharmacy intern, as defined by section sixty-eight hundred six of the education law, or other individual as may be permitted by the commissioner in regulation, to consult the prescription monitoring program registry on the pharmacist's behalf, provided that such designee is employed by the same pharmacy or is under contract with such pharmacy. The commissioner shall establish in regulation reasonable parameters with regard to a pharmacist's ability to authorize designees pursuant to this section, which shall include processes necessary to allow the department to: (A) grant access to the registry in a reasonably prompt manner to as many designees as are authorized by pharmacists, up to the number deemed appropriate by the commissioner for particular pharmacies, taking into account the need to maintain security of the registry and the patient-specific information maintained therein, and the objective of minimizing burdens to pharmacists to the extent practicable; (B) require that pharmacists notify the department upon terminating the authorization of any designee; and (C) establish a mechanism to prevent such terminated designees from accessing the registry in a reasonably prompt manner following such notification.

4. Immunity. No practitioner or pharmacist, and no person acting on behalf of such practitioner or pharmacist as permitted under this section, acting with reasonable care and in good faith shall be subject to civil liability arising from any false, incomplete or inaccurate information submitted to or reported by the registry or for any resulting failure of the system to accurately or timely report such information; provided, however, that nothing in this subdivision shall be deemed to alter the obligation to submit or report prescription information to the department as otherwise set forth in this article or in regulations promulgated pursuant thereto.

5. Guidance to practitioners and pharmacists. The commissioner shall, in consultation with the commissioner of education, provide guidance to

practitioners, pharmacists, and pharmacies regarding the purposes and uses of the registry established by this section and the means by which practitioners and pharmacists can access the registry. Such guidance shall reference educational information available pursuant to the prescription pain medication awareness program established pursuant to section thirty-three hundred nine-a of this article.

6. Individual access to controlled substance histories. The commissioner shall establish procedures by which an individual may: (a) request and obtain his or her own controlled substances history consisting of patient-specific information or, in appropriate circumstances, that of a patient who lacks capacity to make health care decisions and for whom the individual has legal authority to make such decisions and would have legal access to the patient's health care records; or (b) seek review of any part of his or her controlled substances history or, in appropriate circumstances, that of a patient who lacks capacity to make health care decisions and for whom the individual has legal authority to make such decisions and would have legal access to the patient's health care records, that such individual disputes. Such procedures shall require the department to promptly revise any information accessible through the registry that the department determines to be inaccurate. Such procedures shall be described on the department's website and included with the controlled substances history provided to an individual pursuant to a request made under this subdivision or under subparagraph (iv) of paragraph (a) of subdivision two of section thirty-three hundred seventy-one of this article.

7. Department analysis of data. The department shall periodically analyze data contained in the prescription monitoring program registry to identify information that indicates that a violation of law or breach of professional standards may have occurred and, as warranted, provide any relevant information to appropriate entities as permitted under section thirty-three hundred seventy-one of this article. The department shall keep a record of the information provided, including, but not limited to, the specific information provided and the agency to which such information was provided, including the name and title of the

person to whom such information was provided and an attestation from such person that he or she has authority to receive such information.

8. Funding the prescription monitoring program registry. (a) The commissioner shall make reasonable efforts to apply for monies available from the federal government and other institutions, to the extent deemed appropriate by the commissioner, and use any monies so obtained to supplement any other monies made available for the purposes of this title.

(b) Operation of the registry established by this section shall not be funded, in whole or in part, by fees imposed specifically for such purposes upon practitioners, pharmacists, designees or patients subject to this section.

9. Rules and regulations. The commissioner shall promulgate such rules and regulations as are necessary to effectuate the provisions of this section, in consultation with the work group established pursuant to subdivision three of section thirty-three hundred nine-a of this article.

§ 3343-b. Safe disposal of unused controlled substances. 1. The department shall oversee a program for the safe disposal of unused controlled substances by consumers in accordance with federal law and article two-B of this chapter. Individual members of the public shall be authorized to voluntarily surrender controlled substances listed on schedule II, III, IV or V of section thirty-three hundred six of this article in a secure manner, without identifying themselves. Safe disposal methods shall be publicized consistent with the prescription pain medication awareness program established pursuant to section thirty-three hundred nine-a of this article and article two-B of this chapter.

2. The surrender of a controlled substance pursuant to this section and article two-B of this chapter shall not constitute the possession, transfer or sale of such controlled substance for purposes of this article or the penal law.

3. Except as provided in article two-B of this chapter, disposal sites shall be operated by law enforcement agencies, pharmacies and other Federal Drug Enforcement Administration authorized collectors on a voluntary basis, provided, however, that such disposal sites shall not be precluded from operating as part of a drug take back program established pursuant to article two-B of this chapter. Nothing in this section shall require any political subdivision of the state to participate in the program established in this section.

§ 3345. Possession of controlled substances by ultimate users original container. Except for the purpose of current use by the person or animal for whom such substance was prescribed or dispensed, it shall be unlawful for an ultimate user of controlled substances to possess such substance outside of the original container in which it was dispensed.

Violation of this provision shall be an offense punishable by a fine of not more than fifty dollars.

TITLE V

DISPENSING TO PERSONS WITH SUBSTANCE USE DISORDER AND HABITUAL USERS

Section 3350. Dispensing prohibition.

3351. Dispensing for medical use.

3352. Reports and records.

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

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

(a) during emergency medical treatment unrelated to abuse of controlled substances;

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

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

2. Controlled substances may be ordered for use by a person with substance use disorder or habitual user by a practitioner and administered by a practitioner or registered nurse to relieve acute withdrawal symptoms.

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

4. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be ordered for use of a person with substance use disorder by a practitioner and dispensed or administered by a practitioner or a such practitioner's designated agent as interim treatment for a person with substance use disorder while arrangements are being made for referral to treatment for such addiction to controlled substances.

5. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered to a person with substance use disorder by a practitioner or by a such practitioner's designated agent acting under the direction and supervision of a practitioner, as part of a regimen designed and intended to withdraw a patient from addiction to controlled substances.

6. Notwithstanding any other law and consistent with federal requirements, methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered or dispensed directly to a person with substance use disorder by a

practitioner or by a such practitioner's designated agent acting under the direction and supervision of a practitioner, as part of a substance use or chemical dependence program approved pursuant to article thirty-two of the mental hygiene law.

§ 3352. Reports and records. Persons certified pursuant to article thirty-two of the mental hygiene law to operate methadone maintenance treatment programs shall keep records showing the receipt, administration, dispensing, or destruction of all controlled substances and documenting each incident or alleged incident involving the theft, loss or possible diversion of controlled substances and shall maintain the records in such manner and detail as the commissioner, by regulation, shall require.

A person certified to conduct a maintenance program shall immediately file a report with the department of each incident or alleged incident involving the theft, loss or possible diversion of controlled substances.

* TITLE V-A

MEDICAL USE OF MARIHUANA

- Section 3360. Definitions.
3361. Certification of patients.
3362. Lawful medical use.
3363. Registry identification cards.
3364. Registered organizations.
3365. Registering of registered organizations.
- 3365-a. Expedited registration of registered organizations.
3366. Reports by registered organizations.
3367. Evaluation; research programs; report by department.
3368. Relation to other laws.
3369. Protections for the medical use of marihuana.
- 3369-a. Regulations.
- 3369-b. Effective date.
- 3369-c. Suspend; terminate.

3369-d. Pricing.

3369-e. Severability.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3360. Definitions.** As used in this title, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Certified medical use" means the acquisition, possession, use, or, transportation of medical marihuana by a certified patient, or the acquisition, possession, delivery, transportation or administration of medical marihuana by a designated caregiver, for use as part of the treatment of the patient's serious condition, as authorized in a certification under this title including enabling the patient to tolerate treatment for the serious condition. A certified medical use does not include smoking.

2. "Caring for" means treating a patient, in the course of which the practitioner has completed a full assessment of the patient's medical history and current medical condition.

3. "Certified patient" means a patient who is a resident of New York state or receiving care and treatment in New York state as determined by the commissioner in regulation, and is certified under section thirty-three hundred sixty-one of this title.

4. "Certification" means a certification, made under section thirty-three hundred sixty-one of this title.

5. "Designated caregiver" means the individual designated by a certified patient in a registry application. A certified patient may designate up to two designated caregivers.

6. "Public place" means a public place as defined in regulation by the

commissioner.

7. (a) "Serious condition" means:

(i) having one of the following severe debilitating or life-threatening conditions: cancer, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, amyotrophic lateral sclerosis, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, post-traumatic stress disorder, pain that degrades health and functional capability where the use of medical marihuana is an alternative to opioid use, substance use disorder, or as added by the commissioner; and

(ii) any of the following conditions where it is clinically associated with, or a complication of, a condition under this paragraph or its treatment: cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures; severe or persistent muscle spasms; or such conditions as are added by the commissioner.

(b) No later than eighteen months from the effective date of this section, the commissioner shall determine whether to add the following serious conditions: Alzheimer's, muscular dystrophy, dystonia, post-traumatic stress disorder and rheumatoid arthritis.

8. "Medical marihuana" means marihuana as defined in subdivision twenty-one of section thirty-three hundred two of this article, intended for a certified medical use, as determined by the commissioner in his or her sole discretion. Any form of medical marihuana not approved by the commissioner is expressly prohibited.

9. "Registered organization" means a registered organization under sections thirty-three hundred sixty-four and thirty-three hundred sixty-five of this title.

10. "Registry application" means an application properly completed and filed with the department by a certified patient under section thirty-three hundred sixty-three of this title.

11. "Registry identification card" means a document that identifies a certified patient or designated caregiver, as provided under section thirty-three hundred sixty-three of this title.

12. "Practitioner" means a practitioner who (i) is a physician licensed by New York state and practicing within the state, (ii) who by training or experience is qualified to treat a serious condition as defined in subdivision seven of this section; and (iii) has completed a two to four hour course as determined by the commissioner in regulation and registered with the department; provided however, a registration shall not be denied without cause. Such course may count toward board certification requirements. The commissioner shall consider the inclusion of nurse practitioners under this title based upon considerations including access and availability. After such consideration the commissioner is authorized to deem nurse practitioners as practitioners under this title.

13. "Terminally ill" means an individual has a medical prognosis that the individual's life expectancy is approximately one year or less if the illness runs its normal course.

14. "Labor peace agreement" means an agreement between an entity and a labor organization that, at a minimum, protects the state's proprietary interests by prohibiting labor organizations and members from engaging in picketing, work stoppages, boycotts, and any other economic interference with the registered organization's business.

15. "Individual dose" means a single measure of raw medical marihuana or non-infused concentrates to be determined and clearly identified by a patient's practitioner for the patient's specific certified condition. For ingestible or sub-lingual medical marihuana products, no individual dose may contain more than ten milligrams of tetrahydrocannabinol.

16. "Form of medical marihuana" means characteristics of the medical marihuana recommended or limited for a particular certified patient, including the method of consumption and any particular strain, variety, and quantity or percentage of marihuana or particular active ingredient.

17. "Applicant" means a for-profit entity or not-for-profit corporation and includes: board members, officers, managers, owners, partners, principal stakeholders and members who submit an application to become a registered organization.

18. "Special certification" means a special certification made under subdivision nine of section thirty-three hundred sixty-one of this title.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3361. Certification of patients.** 1. A patient certification may only be issued if: (a) a practitioner has been registered with the department to issue a certification as determined by the commissioner; (b) the patient has a serious condition, which shall be specified in the patient's health care record; (c) the practitioner by training or experience is qualified to treat the serious condition; (d) the patient is under the practitioner's continuing care for the serious condition; and (e) in the practitioner's professional opinion and review of past treatments, the patient is likely to receive therapeutic or palliative benefit from the primary or adjunctive treatment with medical use of marihuana for the serious condition.

2. The certification shall include (a) the name, date of birth and address of the patient; (b) a statement that the patient has a serious condition and the patient is under the practitioner's care for the serious condition; (c) a statement attesting that all requirements of subdivision one of this section have been satisfied; (d) the date; and (e) the name, address, federal registration number, telephone number, and the handwritten signature of the certifying practitioner. The commissioner may require by regulation that the certification shall be on a form provided by the department. The practitioner may state in the certification that, in the practitioner's professional opinion, the patient would benefit from medical marihuana only until a specified

date. The practitioner may state in the certification that, in the practitioner's professional opinion, the patient is terminally ill and that the certification shall not expire until the patient dies.

3. In making a certification, the practitioner shall consider the form of medical marihuana the patient should consume, including the method of consumption and any particular strain, variety, and quantity or percentage of marihuana or particular active ingredient, and appropriate dosage. The practitioner shall state in the certification any recommendation or limitation the practitioner makes, in his or her professional opinion, concerning the appropriate form or forms of medical marihuana and dosage.

4. Every practitioner shall consult the prescription monitoring drug program registry prior to making or issuing a certification, for the purpose of reviewing a patient's controlled substance history. For purposes of this section, a practitioner may authorize a designee to consult the prescription monitoring program registry on his or her behalf, provided that such designation is in accordance with section thirty-three hundred forty-three-a of this article.

5. The practitioner shall give the certification to the certified patient, and place a copy in the patient's health care record.

6. No practitioner shall issue a certification under this section for himself or herself.

7. A registry identification card based on a certification shall expire one year after the date the certification is signed by the practitioner.

8. (a) If the practitioner states in the certification that, in the practitioner's professional opinion, the patient would benefit from medical marihuana only until a specified earlier date, then the registry identification card shall expire on that date;

(b) If the practitioner states in the certification that in the practitioner's professional opinion the patient is terminally ill and

that the certification shall not expire until the patient dies, then the registry identification card shall state that the patient is terminally ill and that the registration card shall not expire until the patient dies;

(c) If the practitioner re-issues the certification to terminate the certification on an earlier date, then the registry identification card shall expire on that date and shall be promptly returned by the certified patient to the department;

(d) If the certification so provides, the registry identification card shall state any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient; and

(e) The commissioner shall make regulations to implement this subdivision.

9.(a) A certification may be a special certification if, in addition to the other requirements for a certification, the practitioner certifies in the certification that the patient's serious condition is progressive and degenerative or that delay in the patient's certified medical use of marihuana poses a serious risk to the patient's life or health.

(b) The department shall create the form to be used for a special certification and shall make that form available to be downloaded from the department's website.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3362. Lawful medical use.** 1. The possession, acquisition, use, delivery, transfer, transportation, or administration of medical marihuana by a certified patient or designated caregiver possessing a valid registry identification card, for certified medical use, shall be lawful under this title; provided that:

(a) the marihuana that may be possessed by a certified patient shall not exceed a thirty day supply of the dosage as determined by the practitioner, consistent with any guidance and regulations issued by the

commissioner, provided that during the last seven days of any thirty day period, the certified patient may also possess up to such amount for the next thirty day period;

(b) the marihuana that may be possessed by designated caregivers does not exceed the quantities referred to in paragraph (a) of this subdivision for each certified patient for whom the caregiver possesses a valid registry identification card, up to five certified patients;

(c) the form or forms of medical marihuana that may be possessed by the certified patient or designated caregiver pursuant to a certification shall be in compliance with any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient in the certification; and

(d) the medical marihuana shall be kept in the original package in which it was dispensed under subdivision twelve of section thirty-three hundred sixty-four of this title, except for the portion removed for immediate consumption for certified medical use by the certified patient.

2. Notwithstanding subdivision one of this section:

(a) possession of medical marihuana shall not be lawful under this title if it is smoked, consumed, vaporized, or grown in a public place, regardless of the form of medical marihuana stated in the patient's certification.

(b) a person possessing medical marihuana under this title shall possess his or her registry identification card at all times when in immediate possession of medical marihuana.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3363. Registry identification cards.** 1. Upon approval of the certification, the department shall issue registry identification cards for certified patients and designated caregivers. A registry identification card shall expire as provided in section thirty-three hundred sixty-one of this title or as otherwise provided in this section. The department shall begin issuing registry identification

cards as soon as practicable after the certifications required by section thirty-three hundred sixty-nine-b are granted. The department may specify a form for a registry application, in which case the department shall provide the form on request, reproductions of the form may be used, and the form shall be available for downloading from the department's website.

2. To obtain, amend or renew a registry identification card, a certified patient or designated caregiver shall file a registry application with the department. The registry application or renewal application shall include:

(a) in the case of a certified patient:

(i) the patient's certification (a new written certification shall be provided with a renewal application);

(ii) the name, address, and date of birth of the patient;

(iii) the date of the certification;

(iv) if the patient has a registry identification card based on a current valid certification, the registry identification number and expiration date of that registry identification card;

(v) the specified date until which the patient would benefit from medical marihuana, if the certification states such a date;

(vi) the name, address, federal registration number, and telephone number of the certifying practitioner;

(vii) any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient; and

(viii) other individual identifying information required by the department;

(b) in the case of a certified patient, if the patient designates a designated caregiver, the name, address, and date of birth of the designated caregiver, and other individual identifying information required by the department;

(c) in the case of a designated caregiver:

(i) the name, address, and date of birth of the designated caregiver;

(ii) if the designated caregiver has a registry identification card, the registry identification number and expiration date of that registry identification card; and

(iii) other individual identifying information required by the department;

(d) a statement that a false statement made in the application is punishable under section 210.45 of the penal law;

(e) the date of the application and the signature of the certified patient or designated caregiver, as the case may be;

(f) a fifty dollar application fee, provided, that the department may waive or reduce the fee in cases of financial hardship; and

(g) any other requirements determined by the commissioner.

3. Where a certified patient is under the age of eighteen:

(a) The application for a registry identification card shall be made by an appropriate person over twenty-one years of age. The application shall state facts demonstrating that the person is appropriate.

(b) The designated caregiver shall be (i) a parent or legal guardian of the certified patient, (ii) a person designated by a parent or legal guardian, or (iii) an appropriate person approved by the department upon a sufficient showing that no parent or legal guardian is appropriate or available.

4. No person may be a designated caregiver if the person is under twenty-one years of age unless a sufficient showing is made to the department that the person should be permitted to serve as a designated caregiver. The requirements for such a showing shall be determined by the commissioner.

5. No person may be a designated caregiver for more than five certified patients at one time.

6. If a certified patient wishes to change or terminate his or her designated caregiver, for whatever reason, the certified patient shall notify the department as soon as practicable. The department shall issue a notification to the designated caregiver that their registration card is invalid and must be promptly returned to the department. The newly designated caregiver must comply with all requirements set forth in this section.

7. If the certification so provides, the registry identification card shall contain any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient.

8. The department shall issue separate registry identification cards for certified patients and designated caregivers as soon as reasonably practicable after receiving a complete application under this section, unless it determines that the application is incomplete or factually inaccurate, in which case it shall promptly notify the applicant.

9. If the application of a certified patient designates an individual as a designated caregiver who is not authorized to be a designated caregiver, that portion of the application shall be denied by the department but that shall not affect the approval of the balance of the application.

10. A registry identification card shall:

(a) contain the name of the certified patient or the designated caregiver as the case may be;

(b) contain the date of issuance and expiration date of the registry identification card;

(c) contain a registry identification number for the certified patient or designated caregiver, as the case may be and a registry identification number;

(d) contain a photograph of the individual to whom the registry identification card is being issued, which shall be obtained by the department in a manner specified by the commissioner in regulations; provided, however, that if the department requires certified patients to submit photographs for this purpose, there shall be a reasonable accommodation of certified patients who are confined to their homes due to their medical conditions and may therefore have difficulty procuring photographs;

(e) be a secure document as determined by the department;

(f) plainly state any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient; and

(g) any other requirements determined by the commissioner.

11. A certified patient or designated caregiver who has been issued a registry identification card shall notify the department of any change in his or her name or address or, with respect to the patient, if he or she ceases to have the serious condition noted on the certification within ten days of such change. The certified patient's or designated caregiver's registry identification card shall be deemed invalid and shall be returned promptly to the department.

12. If a certified patient or designated caregiver loses his or her registry identification card, he or she shall notify the department and submit a twenty-five dollar fee within ten days of losing the card to maintain the registration. The department may establish higher fees for issuing a new registry identification card for second and subsequent replacements for a lost card, provided, that the department may waive or reduce the fee in cases of financial hardship. The department shall issue a new registry identification card as soon as practicable, which may contain a new registry identification number, to the certified patient or designated caregiver, as the case may be. The certified patient or designated caregiver shall not be able to obtain medical marihuana until the certified patient receives a new card.

13. The department shall maintain a confidential list of the persons to whom it has issued registry identification cards. Individual identifying information obtained by the department under this title shall be confidential and exempt from disclosure under article six of the public officers law. Notwithstanding this subdivision, the department may notify any appropriate law enforcement agency of information relating to any violation or suspected violation of this title.

14. The department shall verify to law enforcement personnel in an appropriate case whether a registry identification card is valid.

15. If a certified patient or designated caregiver willfully violates any provision of this title as determined by the department, his or her

registry identification card may be suspended or revoked. This is in addition to any other penalty that may apply.

16. The commissioner shall make regulations for special certifications, which shall include expedited procedures and which may require the applicant to submit additional documentation establishing the clinical basis for the special certification. If the department has not established and made available a form for a registry application or renewal application and determined the application fee if any, or established and made available a form for a registry application or renewal application and determined the application fee for a special certification, then in the case of a special certification, a registry application or renewal application that otherwise conforms with the requirements of this section shall not require the use of a form or the payment of an application fee.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3364. Registered organizations.** 1. A registered organization shall be a for-profit business entity or not-for-profit corporation organized for the purpose of acquiring, possessing, manufacturing, selling, delivering, transporting, distributing or dispensing marihuana for certified medical use.

2. The acquiring, possession, manufacture, sale, delivery, transporting, distributing or dispensing of marihuana by a registered organization under this title in accordance with its registration under section thirty-three hundred sixty-five of this title or a renewal thereof shall be lawful under this title.

3. Each registered organization shall contract with an independent laboratory to test the medical marihuana produced by the registered organization. The commissioner shall approve the laboratory and require that the laboratory report testing results in a manner determined by the commissioner. The commissioner is authorized to issue regulation

requiring the laboratory to perform certain tests and services.

4. (a) A registered organization may lawfully, in good faith, sell, deliver, distribute or dispense medical marihuana to a certified patient or designated caregiver upon presentation to the registered organization of a valid registry identification card for that certified patient or designated caregiver. When presented with the registry identification card, the registered organization shall provide to the certified patient or designated caregiver a receipt, which shall state: the name, address, and registry identification number of the registered organization; the name and registry identification number of the certified patient and the designated caregiver (if any); the date the marihuana was sold; any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient; and the form and the quantity of medical marihuana sold. The registered organization shall retain a copy of the registry identification card and the receipt for six years.

(b) The proprietor of a registered organization shall file or cause to be filed any receipt and certification information with the department by electronic means on a real time basis as the commissioner shall require by regulation. When filing receipt and certification information electronically pursuant to this paragraph, the proprietor of the registered organization shall dispose of any electronically recorded prescription information in such manner as the commissioner shall by regulation require.

5. (a) No registered organization may sell, deliver, distribute or dispense to any certified patient or designated caregiver a quantity of medical marihuana larger than that individual would be allowed to possess under this title.

(b) When dispensing medical marihuana to a certified patient or designated caregiver, the registered organization (i) shall not dispense an amount greater than a thirty day supply to a certified patient until the certified patient has exhausted all but a seven day supply provided pursuant to a previously issued certification, and (ii) shall verify the information in subparagraph (i) of this paragraph by consulting the prescription monitoring program registry under section thirty-three

hundred forty-three-a of this article.

(c) Medical marihuana dispensed to a certified patient or designated caregiver by a registered organization shall conform to any recommendation or limitation by the practitioner as to the form or forms of medical marihuana or dosage for the certified patient.

6. When a registered organization sells, delivers, distributes or dispenses medical marihuana to a certified patient or designated caregiver, it shall provide to that individual a safety insert, which will be developed and approved by the commissioner and include, but not be limited to, information on:

- (a) methods for administering medical marihuana in individual doses,
- (b) any potential dangers stemming from the use of medical marihuana,
- (c) how to recognize what may be problematic usage of medical marihuana and obtain appropriate services or treatment for problematic usage, and
- (d) other information as determined by the commissioner.

7. Registered organizations shall not be managed by or employ anyone who has been convicted of any felony of sale or possession of drugs, narcotics, or controlled substances provided that this subdivision only applies to (a) managers or employees who come into contact with or handle medical marihuana, and (b) a conviction less than ten years (not counting time spent in incarceration) prior to being employed, for which the person has not received a certificate of relief from disabilities or a certificate of good conduct under article twenty-three of the correction law.

8. Manufacturing of medical marihuana by a registered organization shall only be done in an indoor, enclosed, secure facility located in New York state, which may include a greenhouse. The commissioner shall promulgate regulations establishing requirements for such facilities.

9. Dispensing of medical marihuana by a registered organization shall only be done in an indoor, enclosed, secure facility located in New York state, which may include a greenhouse. The commissioner shall promulgate regulations establishing requirements for such facilities.

10. A registered organization shall determine the quality, safety, and clinical strength of medical marihuana manufactured or dispensed by the registered organization, and shall provide documentation of that quality, safety and clinical strength to the department and to any person or entity to which the medical marihuana is sold or dispensed.

11. A registered organization shall be deemed to be a "health care provider" for the purposes of title two-D of article two of this chapter.

12. Medical marihuana shall be dispensed to a certified patient or designated caregiver in a sealed and properly labeled package. The labeling shall contain: (a) the information required to be included in the receipt provided to the certified patient or designated caregiver by the registered organization; (b) the packaging date; (c) any applicable date by which the medical marihuana should be used; (d) a warning stating, "This product is for medicinal use only. Women should not consume during pregnancy or while breastfeeding except on the advice of the certifying health care practitioner, and in the case of breastfeeding mothers, including the infant's pediatrician. This product might impair the ability to drive. Keep out of reach of children."; (e) the amount of individual doses contained within; and (f) a warning that the medical marihuana must be kept in the original container in which it was dispensed.

13. The commissioner is authorized to make rules and regulations restricting the advertising and marketing of medical marihuana, which shall be consistent with the federal regulations governing prescription drug advertising and marketing.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3365. Registering of registered organizations.** 1. Application for initial registration. (a) An applicant for registration as a registered

organization under section thirty-three hundred sixty-four of this title shall include such information prepared in such manner and detail as the commissioner may require, including but not limited to:

(i) a description of the activities in which it intends to engage as a registered organization;

(ii) that the applicant:

(A) is of good moral character;

(B) possesses or has the right to use sufficient land, buildings, and other premises (which shall be specified in the application) and equipment to properly carry on the activity described in the application, or in the alternative posts a bond of not less than two million dollars;

(C) is able to maintain effective security and control to prevent diversion, abuse, and other illegal conduct relating to the marijuana;

(D) is able to comply with all applicable state laws and regulations relating to the activities in which it intends to engage under the registration;

(iii) that the applicant has entered into a labor peace agreement with a bona-fide labor organization that is actively engaged in representing or attempting to represent the applicant's employees. The maintenance of such a labor peace agreement shall be an ongoing material condition of certification.

(iv) the applicant's status under subdivision one of section thirty-three hundred sixty-four of this title; and

(v) the application shall include the name, residence address and title of each of the officers and directors and the name and residence address of any person or entity that is a member of the applicant. Each such person, if an individual, or lawful representative if a legal entity, shall submit an affidavit with the application setting forth:

(A) any position of management or ownership during the preceding ten years of a ten per centum or greater interest in any other business, located in or outside this state, manufacturing or distributing drugs;

(B) whether such person or any such business has been convicted of a felony or had a registration or license suspended or revoked in any administrative or judicial proceeding; and

(C) such other information as the commissioner may reasonably require.

2. Duty to report. The applicant shall be under a continuing duty to report to the department any change in facts or circumstances reflected in the application or any newly discovered or occurring fact or circumstance which is required to be included in the application.

3. Granting of registration. (a) The commissioner shall grant a registration or amendment to a registration under this section if he or she is satisfied that:

(i) the applicant will be able to maintain effective control against diversion of marihuana;

(ii) the applicant will be able to comply with all applicable state laws;

(iii) the applicant and its officers are ready, willing and able to properly carry on the manufacturing or distributing activity for which a registration is sought;

(iv) the applicant possesses or has the right to use sufficient land, buildings and equipment to properly carry on the activity described in the application;

(v) it is in the public interest that such registration be granted; the commissioner may consider whether the number of registered organizations in an area will be adequate or excessive to reasonably serve the area;

(vi) the applicant and its managing officers are of good moral character;

(vii) the applicant has entered into a labor peace agreement with a bona-fide labor organization that is actively engaged in representing or attempting to represent the applicant's employees; and

(viii) the applicant satisfies any other conditions as determined by the commissioner.

(b) If the commissioner is not satisfied that the applicant should be issued a registration, he or she shall notify the applicant in writing of those factors upon which further evidence is required. Within thirty days of the receipt of such notification, the applicant may submit additional material to the commissioner or demand a hearing, or both.

(c) The fee for a registration under this section shall be a reasonable amount determined by the department in regulations; provided, however, if the registration is issued for a period greater than two

years the fee shall be increased, pro rata, for each additional month of validity.

(d) Registrations issued under this section shall be effective only for the registered organization and shall specify:

(i) the name and address of the registered organization;

(ii) which activities of a registered organization are permitted by the registration;

(iii) the land, buildings and facilities that may be used for the permitted activities of the registered organization; and

(iv) such other information as the commissioner shall reasonably provide to assure compliance with this title.

(e) Upon application of a registered organization, a registration may be amended to allow the registered organization to relocate within the state or to add or delete permitted registered organization activities or facilities. The fee for such amendment shall be two hundred fifty dollars.

4. A registration issued under this section shall be valid for two years from the date of issue, except that in order to facilitate the renewals of such registrations, the commissioner may upon the initial application for a registration, issue some registrations which may remain valid for a period of time greater than two years but not exceeding an additional eleven months.

5. Applications for renewal of registrations. (a) An application for the renewal of any registration issued under this section shall be filed with the department not more than six months nor less than four months prior to the expiration thereof. A late-filed application for the renewal of a registration may, in the discretion of the commissioner, be treated as an application for an initial license.

(b) The application for renewal shall include such information prepared in the manner and detail as the commissioner may require, including but not limited to:

(i) any material change in the circumstances or factors listed in subdivision one of this section; and

(ii) every known charge or investigation, pending or concluded during the period of the registration, by any governmental or administrative

agency with respect to:

(A) each incident or alleged incident involving the theft, loss, or possible diversion of marihuana manufactured or distributed by the applicant; and

(B) compliance by the applicant with the laws of the state with respect to any substance listed in section thirty-three hundred six of this article.

(c) An applicant for renewal shall be under a continuing duty to report to the department any change in facts or circumstances reflected in the application or any newly discovered or occurring fact or circumstance which is required to be included in the application.

(d) If the commissioner is not satisfied that the applicant is entitled to a renewal of the registration, he or she shall within a reasonably practicable time as determined by the commissioner, serve upon the applicant or his or her attorney of record in person or by registered or certified mail an order directing the applicant to show cause why his or her application for renewal should not be denied. The order shall specify in detail the respects in which the applicant has not satisfied the commissioner that the registration should be renewed.

(e) Within a reasonably practicable time as determined by the commissioner of such order, the applicant may submit additional material to the commissioner or demand a hearing or both. If a hearing is demanded the commissioner shall fix a date as soon as reasonably practicable.

6. Granting of renewal of registrations. (a) The commissioner shall renew a registration unless he or she determines and finds that:

(i) the applicant is unlikely to maintain or be able to maintain effective control against diversion; or

(ii) the applicant is unlikely to comply with all state laws applicable to the activities in which it may engage under the registration; or

(iii) it is not in the public interest to renew the registration because the number of registered organizations in an area is excessive to reasonably serve the area; or

(iv) the applicant has either violated or terminated its labor peace agreement.

(b) For purposes of this section, proof that a registered organization, during the period of its registration, has failed to maintain effective control against diversion, violates any provision of this article, or has knowingly or negligently failed to comply with applicable state laws relating to the activities in which it engages under the registration, shall constitute grounds for suspension or termination of the registered organization's registration as determined by the commissioner. The registered organization shall also be under a continuing duty to report to the department any material change or fact or circumstance to the information provided in the registered organization's application.

7. The department may suspend or terminate the registration of a registered organization, on grounds and using procedures under this article relating to a license, to the extent consistent with this title. The department shall suspend or terminate the registration in the event that a registered organization violates or terminates the applicable labor peace agreement. Conduct in compliance with this title which may violate conflicting federal law, shall not be grounds to suspend or terminate a registration.

8. The department shall begin issuing registrations for registered organizations as soon as practicable after the certifications required by section thirty-three hundred sixty-nine-b of this title are given.

9. The commissioner shall register no more than five registered organizations that manufacture medical marihuana with no more than four dispensing sites wholly owned and operated by such registered organization. The commissioner shall ensure that such registered organizations and dispensing sites are geographically distributed across the state. The commission may register additional registered organizations.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3365-a. Expedited registration of registered organizations. 1.**

There is hereby established in the department an emergency medical marihuana access program (referred to in this section as the "program") under this section. The purpose of the program is to expedite the availability of medical marihuana to avoid suffering and loss of life, during the period before full implementation of and production under this title, especially in the case of patients whose serious condition is progressive and degenerative or is such that delay in the patient's medical use of marihuana poses a serious risk to the patient's life or health. The commissioner shall implement the program as expeditiously as practicable, including by emergency regulation.

2. The department shall begin accepting and acting on applications under this section for registered organizations as soon as practicable after the effective date of this section.

3. For the purposes of this section, and for specified limited times, the commissioner may waive or modify the requirements of this article relating to registered organizations, consistent with the legislative intent and purpose of this title and this section. Where an entity seeking to be a registered organization under the program operates in a jurisdiction other than the state of New York, under licensure or other governmental recognition of that jurisdiction, and the laws of that jurisdiction are acceptable to the commissioner as consistent with the legislative intent and purpose of this title and this section, then the commissioner may accept that licensure or recognition as wholly or partially satisfying the requirements of this title, for purposes of the registration and operation of the registered organization under the program and this section.

4. In considering an application for registration as a registered organization under this section, the commissioner shall give preference to the following:

(a) an applicant that is currently producing or providing or has a history of producing or providing medical marihuana in another jurisdiction in full compliance with the laws of the jurisdiction;

(b) an applicant that is able and qualified to both produce,

distribute, and dispense medical marihuana to patients expeditiously;

(c) an applicant that proposes a location or locations for dispensing by the registered organization, which ensure, to the greatest extent possible, that certified patients with a special certification have access to a registered organization.

5. The commissioner may make regulations under this section:

(a) limiting registered organizations registered under this section to serving patients with special certifications;

(b) limiting the allowable levels of cannabidiol and tetrahydrocannabinol that may be contained in medical marihuana authorized under the program, based on therapeutics and patient safety.

6. A registered organization under this section may apply under section thirty-three hundred sixty-five of this title to receive or renew registration.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3366. Reports by registered organizations.** 1. The commissioner shall, by regulation, require each registered organization to file reports by the registered organization during a particular period. The commissioner shall determine the information to be reported and the forms, time, and manner of the reporting.

2. The commissioner shall, by regulation, require each registered organization to adopt and maintain security, tracking, record keeping, record retention and surveillance systems, relating to all medical marihuana at every stage of acquiring, possession, manufacture, sale, delivery, transporting, distributing, or dispensing by the registered organization, subject to regulations of the commissioner.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3367. Evaluation; research programs; report by department.** 1. The commissioner may provide for the analysis and evaluation of the operation of this title. The commissioner may enter into agreements with one or more persons, not-for-profit corporations or other organizations, for the performance of an evaluation of the implementation and effectiveness of this title.

2. The department may develop, seek any necessary federal approval for, and carry out research programs relating to medical use of marihuana. Participation in any such research program shall be voluntary on the part of practitioners, patients, and designated caregivers.

3. The department shall report every two years, beginning two years after the effective date of this title, to the governor and the legislature on the medical use of marihuana under this title and make appropriate recommendations.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3368. Relation to other laws.** 1. (a) The provisions of this article shall apply to this title, except that where a provision of this title conflicts with another provision of this article, this title shall apply.

(b) Medical marihuana shall not be deemed to be a "drug" for purposes of article one hundred thirty-seven of the education law.

2. Nothing in this title shall be construed to require an insurer or health plan under this chapter or the insurance law to provide coverage for medical marihuana. Nothing in this title shall be construed to require coverage for medical marihuana under article twenty-five of this chapter or article five of the social services law.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been

appointed

*** § 3369. Protections for the medical use of marihuana.** 1. Certified patients, designated caregivers, practitioners, registered organizations and the employees of registered organizations shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, solely for the certified medical use or manufacture of marihuana, or for any other action or conduct in accordance with this title.

2. Non-discrimination. Being a certified patient shall be deemed to be having a "disability" under article fifteen of the executive law (human rights law), section forty-c of the civil rights law, sections 240.00, 485.00, and 485.05 of the penal law, and section 200.50 of the criminal procedure law. This subdivision shall not bar the enforcement of a policy prohibiting an employee from performing his or her employment duties while impaired by a controlled substance. This subdivision shall not require any person or entity to do any act that would put the person or entity in violation of federal law or cause it to lose a federal contract or funding.

3. The fact that a person is a certified patient and/or acting in accordance with this title, shall not be a consideration in a proceeding pursuant to applicable sections of the domestic relations law, the social services law and the family court act.

4. (a) Certification applications, certification forms, any certified patient information contained within a database, and copies of registry identification cards shall be deemed exempt from public disclosure under sections eighty-seven and eighty-nine of the public officers law.

(b) The name, contact information, and other information relating to practitioners registered with the department under this title shall be public information and shall be maintained by the commissioner on the department's website accessible to the public in searchable form.

However, if a practitioner notifies the department in writing that he or she does not want his or her name and other information disclosed, that practitioner's name and other information shall thereafter not be public information or maintained on the department's website, unless the practitioner cancels the request.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3369-a. Regulations.** The commissioner shall make regulations to implement this title.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3369-b. Effective date.** Registry identification cards or registered organization registrations shall be issued or become effective no later than eighteen months from signing or until such time as the commissioner and the superintendent of state police certify that this title can be implemented in accordance with public health and safety interests, whichever event comes later. Prior to making a general certification under this section, the commissioner and the superintendent of state police may make a certification limited to accommodating expedited access for patients with special certifications and for registered organizations under the emergency medical marihuana access program under section thirty-three hundred sixty-five-a of this title.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3369-c. Suspend; terminate.** Based upon the recommendation of the commissioner and/or the superintendent of state police that there is a risk to the public health or safety, the governor may immediately

terminate all licenses issued to registered organizations.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3369-d. Pricing.** 1. Every sale of medical marihuana shall be at the price determined by the commissioner. Every charge made or demanded for medical marihuana not in accordance with the price determined by the commissioner, is prohibited.

2. The commissioner is hereby authorized to set the per dose price of each form of medical marihuana sold by any registered organization. In setting the per dose price of each form of medical marihuana, the commissioner shall consider the fixed and variable costs of producing the form of marihuana and any other factor the commissioner, in his or her discretion, deems relevant to determining the per dose price of each form of medical marihuana.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3369-e. Severability.** If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

* NB Repealed July 5, 2028 and Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

TITLE VI

RECORDS AND REPORTS

Section 3370. Preserving and inspection of records.

3371. Confidentiality of certain records, reports, and information.

3371-a. Disclosure of certain records, reports, and information to another state.

3373. Confidential communications.

3374. Notification by licensee.

§ 3370. Preserving and inspection of records. 1. Any record, including prescriptions, required to be kept or maintained by this article shall be preserved for a period of at least five years following the date of the event or transaction recorded, unless a shorter period of time is specifically provided.

2. Such records shall be made available during business hours for inspection and copying by any officer or employee of the department who is charged with the enforcement of this article and to any officer or employee of this state charged with the duty of regulating or licensing of any person who by virtue of such license is authorized to obtain, distribute, dispense or administer controlled substances.

3. Every record, including prescriptions, required to be kept under this article shall be maintained at the premises where the licensed activity is conducted.

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

5. Electronic prescription records shall be maintained and preserved in accordance with regulations of the commissioner.

§ 3371. Confidentiality of certain records, reports, and information.

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

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

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

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

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

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

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

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

(h) to a local health department for the purpose of conducting public health research or education: (i) pursuant to an agreement with the commissioner; (ii) when the release of such information is deemed appropriate by the commissioner; (iii) for use in accordance with

measures required by the commissioner to ensure that the security and confidentiality of the data is protected; and (iv) provided that disclosure is restricted to individuals within the local health department who are engaged in the research or education;

(i) to a medical examiner or coroner who is an officer of or employed by a state or local government, pursuant to his or her official duties; and

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

* 2. The prescription monitoring program registry may be accessed, under such terms and conditions as are established by the department for purposes of maintaining the security and confidentiality of the information contained in the registry, by:

(a) a practitioner, or a designee authorized by such practitioner pursuant to paragraph (b) of subdivision two of section thirty-three hundred forty-three-a, section thirty-three hundred sixty-one of this article or section thirty of the cannabis law, for the purposes of: (i) informing the practitioner that a patient may be under treatment with a controlled substance by another practitioner; (ii) providing the practitioner with notifications of controlled substance activity as deemed relevant by the department, including but not limited to a notification made available on a monthly or other periodic basis through the registry of controlled substances activity pertaining to his or her patient; (iii) allowing the practitioner, through consultation of the prescription monitoring program registry, to review his or her patient's controlled substances history as required by section thirty-three hundred forty-three-a, section thirty-three hundred sixty-one of this article or section thirty of the cannabis law; and (iv) providing to his or her patient, or person authorized pursuant to paragraph (j) of subdivision one of this section, upon request, a copy of such patient's

controlled substance history as is available to the practitioner through the prescription monitoring program registry; or

(b) a pharmacist, pharmacy intern or other designee authorized by the pharmacist pursuant to paragraph (b) of subdivision three of section thirty-three hundred forty-three-a of this article, for the purposes of: (i) consulting the prescription monitoring program registry to review the controlled substances history of an individual for whom one or more prescriptions for controlled substances or certifications for cannabis is presented to the pharmacist, pursuant to section thirty-three hundred forty-three-a of this article; and (ii) receiving from the department such notifications of controlled substance activity as are made available by the department; or

(c) an individual employed by a registered organization as defined in section three of the cannabis law, for the purpose of consulting the prescription monitoring program registry to review the controlled substances history of an individual for whom one or more certifications for cannabis is presented to that registered organization, pursuant to section thirty-three hundred sixty-four of this article or section thirty-four of the cannabis law. Unless otherwise authorized by this article or by the cannabis law, an individual employed by a registered organization will be provided access to the prescription monitoring program in the sole discretion of the commissioner.

* NB Effective until July 5, 2028

* 2. The prescription monitoring program registry may be accessed, under such terms and conditions as are established by the department for purposes of maintaining the security and confidentiality of the information contained in the registry, by:

(a) a practitioner, or a designee authorized by such practitioner pursuant to paragraph (b) of subdivision two of section thirty-three hundred forty-three-a of this article, for the purposes of: (i) informing the practitioner that a patient may be under treatment with a controlled substance by another practitioner; (ii) providing the practitioner with notifications of controlled substance activity as deemed relevant by the department, including but not limited to a notification made available on a monthly or other periodic basis through the registry of controlled substances activity pertaining to his or her patient; (iii) allowing the practitioner, through consultation of the

prescription monitoring program registry, to review his or her patient's controlled substances history as required by section thirty-three hundred forty-three-a of this article; and (iv) providing to his or her patient, or person authorized pursuant to paragraph (j) of subdivision one of this section, upon request, a copy of such patient's controlled substance history as is available to the practitioner through the prescription monitoring program registry; or

(b) a pharmacist, pharmacy intern or other designee authorized by the pharmacist pursuant to paragraph (b) of subdivision three of section thirty-three hundred forty-three-a of this article, for the purposes of: (i) consulting the prescription monitoring program registry to review the controlled substances history of an individual for whom one or more prescriptions for controlled substances is presented to the pharmacist, pursuant to section thirty-three hundred forty-three-a of this article; and (ii) receiving from the department such notifications of controlled substance activity as are made available by the department.

* NB Effective July 5, 2028

3. Where it has reason to believe that a crime related to the diversion of controlled substances has been committed, the department may notify appropriate law enforcement agencies and provide relevant information about the suspected criminal activity, including controlled substances prescribed or dispensed, as reasonably appears to be necessary. The department shall keep a record of the information provided, including, but not limited to: the specific information provided and the agency to which such information was provided, including the name and title of the person to whom such information was provided and an attestation from such person that he or she has authority to receive such information.

4. In the course of any proceeding where such information is disclosed, except when necessary to effectuate the rights of a party to the proceeding, the court or presiding officer shall take such action as is necessary to insure that such information, or record or report of such information is not made public.

§ 3371-a. Disclosure of certain records, reports, and information to another state. 1. The commissioner is authorized to disclose records, reports and information filed pursuant to sections thirty-three hundred thirty-one and thirty-three hundred thirty-three of this article: (a) to another state's controlled substance monitoring program or other authorized agency with which the department has established an interoperability agreement, pursuant to judicial subpoena or court order in a criminal investigation or proceeding in that state;

(b) to another state's agency, department, or board with which the department has established an interoperability agreement and which is authorized to regulate, license, register or otherwise supervise a person who is authorized by law to deal in controlled substances, in the course of any investigation or proceeding by or before such agency, department or board;

(c) to another state's controlled substance monitoring program or other authorized agency with which the department has established an interoperability agreement to inform a practitioner in another state that a patient may be under treatment with a controlled substance by another practitioner; or

(d) to another state's controlled substance monitoring program or other authorized agency with which the department has established an interoperability agreement to inform a pharmacy in another state that a person who presents or has presented a prescription for one or more controlled substances at the pharmacy may have also obtained controlled substances at another pharmacy where the circumstances indicate a possibility of drug abuse or diversion, potential harm to the person, or similar grounds under regulations of the commissioner.

2. Records, reports, and information disclosed under the provisions of this section shall be in accordance with regulations promulgated by the commissioner and shall include, but not be limited to:

(a) the authentication of the person requesting such information;

(b) an attestation from the person requesting the information that he or she has authority to request and receive such information, and that such information will only be used consistent with the purpose of the request for such information;

(c) a statement of the purpose of the request for such information;

and

(d) ensuring that such information is, or will be, transmitted in a secure manner.

3. Every agreement under subdivision one of this section shall:

(a) require reciprocity with the department on the part of every other party to the agreement;

(b) guarantee protection for the confidentiality of information disclosed at least as strong as the protections that would apply to the information when in the possession of the department, including remedies for breaches of confidentiality; and

(c) be subject to renewal not less frequently than every two years.

§ 3373. Confidential communications. For the purposes of duties arising out of this article, no communication made to a practitioner shall be deemed confidential within the meaning of the civil practice law and rules relating to confidential communications between such practitioner and patient.

§ 3374. Notification by licensee. Persons licensed or certified pursuant to this article shall be under a continuing duty to promptly notify the department of:

1. Each incident or alleged incident of theft, loss or possible diversion of controlled substances manufactured, ordered, distributed or possessed by such person;

2. Any charge or proceeding brought in any court or before any governmental agency, state or federal, in which it is alleged that the licensee, its employees, subsidiaries, managing officers, or directors has failed to comply with the provisions of the federal controlled substances act or the laws of any state relating to controlled substances.

TITLE VII

OFFENSES, VIOLATIONS AND ENFORCEMENT

- Section 3380. Inhalation of certain toxic vapors or fumes, and certain hazardous inhalants; sale of glue and hazardous inhalants in certain cases.
3381. Sale and possession of hypodermic syringes and hypodermic needles.
- 3381-a. Destruction of hypodermic syringes and needles.
3383. Imitation controlled substances.
3384. Information program for retailers.
3385. Enforcement.
- 3385-a. Access to criminal history information.
3387. Seizure and forfeiture of controlled substances, imitation controlled substances and official New York state prescription forms; disposition.
3388. Seizure and forfeiture of vehicles, vessels or aircraft unlawfully used to conceal, convey or transport controlled substances.
3390. Revocation of licenses and certificates of approval.
3391. Revocation and suspension of license or certificate of approval procedure.
3393. Formal hearings procedure.
3394. Judicial review.
3396. Violations; penalties.
3397. Fraud and deceit.

§ 3380. Inhalation of certain toxic vapors or fumes, and certain hazardous inhalants; sale of glue and hazardous inhalants in certain cases. 1. (a) As used in this section the phrase "glue containing a solvent having the property of releasing toxic vapors or fumes" shall mean and include any glue, cement, or other adhesive containing one or more of the following chemical compounds: acetone, cellulose acetate, benzene, butyl alcohol, ethyl alcohol, ethylene dichloride, ethylene trichloride, isopropyl alcohol, methyl alcohol, methyl ethyl ketone, pentachlorophenol, petroleum ether, toluene or such other similar material as the commissioner shall by regulation prescribe.

(b) As used in this section hazardous inhalants shall mean and include any of the preparations of compounds containing one or more of the chemical compounds; amyl nitrite, isoamyl nitrite, butyl nitrite, isobutyl nitrite, pentyl nitrite or any other alkyl nitrite compound that is either designed to be used, or commonly used, as an inhalant.

2. No person shall, for the purpose of causing a condition of intoxication, inebriation, excitement, stupefaction, or the dulling of his brain or nervous system, intentionally smell or inhale the fumes from any hazardous inhalants or from any glue containing a solvent having the property of releasing toxic vapors or fumes; provided, that nothing in this section shall be interpreted as applying to the inhalation of any anesthesia or inhalant for medical or dental purposes.

3. No person shall, for the purpose of violating subdivision two, use, or possess for the purpose of so using, any hazardous inhalants or any glue containing a solvent having the property of releasing toxic vapors or fumes.

4. No person shall sell, or offer to sell, to any other person any tube or other container of any hazardous inhalants or glue containing a solvent having the property of releasing toxic vapors or fumes:

(a) if he has knowledge that the product sold, or offered for sale, will be used for the purpose set forth in subdivision two of this section; or

(b) unless there has been added to such glue a sufficient quantity of an additive, approved by the commission, which shall act as a deterrent to inhalation, and not be harmful or toxic to the human body. This provision shall not apply to hazardous inhalants or glue manufactured and sold for industrial use.

5. (a) No person shall use nitrous oxide for purposes of causing intoxication, inebriation, excitement, stupefaction or the dulling of the brain or nervous system of himself or another.

(b) No person shall sell any canister or other container of nitrous oxide unless granted an exemption pursuant to this subdivision. In no event shall any canister or other container of nitrous oxide be sold to

a person under the age of twenty-one years.

(c) This subdivision shall not apply to the use of nitrous oxide in industrial, medical or dental applications, or to specific products which must use nitrous oxide as a propellant provided such products shall in no event be sold at retail to the public, as shall be determined by the commissioner pursuant to paragraph (d) of this subdivision.

(d) The commissioner is directed to promulgate regulations to exempt specific products which must use nitrous oxide, or a mixture of nitrous oxide with other gases, as a propellant from the provisions of this chapter provided such regulations shall prohibit the sale of such products at retail to the public.

(e) The provisions of this section shall not be deemed to prohibit the sale of food products containing nitrous oxide provided such products comply with the provisions of section sixteen-a of the agriculture and markets law.

(f) The commissioner may, upon the application of a manufacturer or seller of a product containing nitrous oxide and intended for sale at retail, authorize the sale of such a product if there is no evidence of substantial misuse of the product as defined by this subdivision and if the manufacturer or seller takes the following steps to:

(i) clearly indicate the legitimate purpose or use of the product on the package;

(ii) display prominently on the package in heavy type print language which warns of health dangers resulting from the misuse of nitrous oxide;

(iii) demonstrate that the product bears a distinctive feature or features enabling it to be clearly distinguished from the nitrous oxide products of other manufacturers;

(iv) educate wholesale and retail businesses which sell the product of the dangers of nitrous oxide and the need to monitor its sale; and

(v) prevent their sale of the product to any person, firm or corporation who or which sells drug-related paraphernalia as such term is defined by subdivision two of section eight hundred fifty of the general business law.

6. (a) Any person who violates any provision of subdivision two or

three of this section shall be guilty of an offense and upon conviction thereof shall be punished by a fine of not more than fifty dollars or by imprisonment for not more than five days, or by both such fine and imprisonment.

(b) Any person who violates any provision of subdivision four or five of this section shall be guilty of a class A misdemeanor.

§ 3381. Sale and possession of hypodermic syringes and hypodermic needles. 1. It shall be unlawful for any person to sell or furnish to another person or persons, a hypodermic syringe or hypodermic needle except:

(a) pursuant to a prescription of a practitioner, which for the purposes of this section shall include a patient specific prescription form as provided for in the education law; or

(b) to persons who have been authorized by the commissioner to obtain and possess such instruments; or

(c) by a pharmacy licensed under article one hundred thirty-seven of the education law, health care facility licensed under article twenty-eight of this chapter or a health care practitioner who is otherwise authorized to prescribe the use of hypodermic needles or syringes within his or her scope of practice; provided, however, that such sale or furnishing: (i) shall only be to a person eighteen years of age or older; and (ii) shall be in accordance with subdivision four of this section; or

(d) under subdivision three of this section.

2. Any person selling or furnishing a hypodermic syringe or hypodermic needle pursuant to a prescription shall record upon the prescription, his or her signature or electronic signature, and the date of the sale or furnishing of the hypodermic syringe or hypodermic needle. Such prescription shall be retained on file for a period of five years and be readily accessible for inspection by any public officer or employee engaged in the enforcement of this section. Such prescription may be refilled not more than the number of times specifically authorized by the prescriber upon the prescription, provided however no such authorization shall be effective for a period greater than two years

from the date the prescription is signed.

3. The commissioner shall, subject to subdivision four of this section, designate persons, or by regulation, classes of persons who may obtain hypodermic syringes and hypodermic needles without prescription and the manner in which such transactions may take place and the records thereof which shall be maintained.

4. (a) A person eighteen years of age or older may obtain and possess a hypodermic syringe or hypodermic needle pursuant to paragraph (c) of subdivision one of this section.

(b) Subject to regulations of the commissioner, a pharmacy licensed under article one hundred thirty-seven of the education law, a health care facility licensed under article twenty-eight of this chapter or a health care practitioner who is otherwise authorized to prescribe the use of hypodermic needles or syringes within his or her scope of practice, may obtain and possess hypodermic needles or syringes for the purpose of selling or furnishing them pursuant to paragraph (c) of subdivision one of this section or for the purpose of disposing of them.

(c) Sale or furnishing of hypodermic syringes or hypodermic needles to direct consumers pursuant to this subdivision by a pharmacy, health care facility, or health care practitioner shall be accompanied by a safety insert. Such safety insert shall be developed or approved by the commissioner and shall include, but not be limited to, (i) information on the proper use of hypodermic syringes and hypodermic needles; (ii) the risk of blood borne diseases that may result from the use of hypodermic syringes and hypodermic needles; (iii) methods for preventing the transmission or contraction of blood borne diseases; (iv) proper hypodermic syringe and hypodermic needle disposal practices; (v) information on the dangers of injection drug use, and how to access drug treatment; (vi) a toll-free phone number for information on the human immunodeficiency virus; and (vii) information on the safe disposal of hypodermic syringes and hypodermic needles including the relevant provisions of the environmental conservation law relating to the unlawful release of regulated medical waste. The safety insert shall be attached to or included in the hypodermic syringe and hypodermic needle packaging, or shall be given to the purchaser at the point of sale or

furnishing in brochure form.

(d) In addition to the requirements of paragraph (c) of subdivision one of this section, a pharmacy licensed under article one hundred thirty-seven of the education law may sell or furnish hypodermic needles or syringes only if such pharmacy stores such needles and syringes in a manner that makes them available only to authorized personnel and not openly available to customers.

(e) A pharmacy registered under article one hundred thirty-seven of the education law may offer counseling and referral services to customers purchasing hypodermic syringes for the purpose of: preventing injection drug abuse; the provision of drug treatment; preventing and treating hepatitis C; preventing drug overdose; testing for the human immunodeficiency virus; and providing pre-exposure prophylaxis and non-occupational post-exposure prophylaxis. The content of such counseling and referral shall be at the professional discretion of the pharmacist.

(f) The commissioner shall promulgate rules and regulations necessary to implement the provisions of this subdivision which shall include: (i) standards for advertising to the public the availability for retail sale or furnishing of hypodermic syringes or needles; and (ii) a requirement that such pharmacies, health care facilities and health care practitioners cooperate in a safe disposal of used hypodermic needles or syringes.

(g) The commissioner may, upon the finding of a violation of this section, suspend for a determinate period of time the sale or furnishing of syringes by a specific entity.

5. The provisions of this section shall not apply to farmers engaged in livestock production or to those persons supplying farmers engaged in livestock production, provided that:

(a) Hypodermic syringes and needles shall be stored in a secure, locked storage container.

(b) At any time the department may request a document outlining:

(i) the number of hypodermic needles and syringes purchased over the past calendar year;

(ii) a record of all hypodermic needles used over the past calendar year; and

(iii) a record of all hypodermic needles and syringes destroyed over the past calendar year.

(c) Hypodermic needles and syringes shall be destroyed in a manner consistent with the provisions set forth in section thirty-three hundred eighty-one-a of this article.

§ 3381-a. Destruction of hypodermic syringes and needles. All hypodermic syringes, needles and disposable hypodermic units which are no longer usable or required shall be crushed, broken or otherwise rendered inoperable in the process of disposal.

The department may specify procedures for disposal of such hypodermic syringes, needles and disposable units as may be necessary to protect public health including, but not limited to, placement of such syringes, needles and units in a leak-proof, puncture resistant container prior to disposal.

§ 3383. Imitation controlled substances. 1. For purposes of this section, the following terms shall have the following meanings:

a. "Manufacture" means the production, preparation, compounding, tableting, processing, encapsulating, packaging, repackaging, labeling or relabeling of an imitation controlled substance.

b. "Markings" means a simulated trademark, trade name, imprinting or other mark, or likeness thereof, of the manufacturer, distributor or dispenser of a controlled substance or a simulated code number or symbol or likeness thereof identifying a controlled substance or combination of such substances.

c. "Imitation controlled substance" means a substance, other than a drug for which a prescription is required pursuant to article one hundred thirty-seven of the education law, that is not a controlled substance, which by dosage unit appearance, including color, shape and size and by a representation is represented to be a controlled

substance, as defined in the penal law. Evidence of representations that the substance is a controlled substance may include but is not limited to oral or written representations by the manufacturer or seller, as the case may be, about the substance with regard to:

- (i) its price, nature, use or effect as a controlled substance; or
- (ii) its packaging in a manner normally used for illicit controlled substances; or
- (iii) markings on the substance.

2. It shall be unlawful for any person to manufacture, sell or possess with the intent to sell, an imitation controlled substance.

3. It shall be unlawful for any person to possess or use any punch, die, plate, stone or any other equipment in order to print, imprint, or reproduce the trademark, trade name or other identifying mark, imprint or device of another or any likeness of any of the foregoing upon any substance or container or labeling thereof with intent to manufacture an imitation controlled substance.

4. No liability shall be imposed by virtue of this section on any person licensed pursuant to article one hundred thirty-one of the education law or licensed under this article who manufactures, distributed, sells, prescribes, dispenses or possesses an imitation controlled substance for use as a placebo or for use in clinical research conducted pursuant to the federal food, drug and cosmetic act.

5. Nothing in this section shall apply to a noncontrolled substance that was initially introduced into commerce prior to the initial introduction into commerce of the controlled substance which it is alleged to imitate.

6. In any prosecution under this section it shall be necessary to prove that the imitation controlled substance was represented to be a controlled substance; however, it shall not be a defense to a prosecution under this section that the accused believed the imitation controlled substance to be a controlled substance.

7. A violation of subdivision two or three of this section shall be a class A misdemeanor. A violation of subdivision two or three of this section by a person previously convicted of a violation of this section within the preceding five years shall be a class E felony.

8. If any provision or part of this section or application thereof is held invalid, the invalidity shall not affect other provisions, parts or applications of this section which can be given effect without the invalid provisions or application, and to this end the provisions of this section are severable.

§ 3384. Information program for retailers. The department shall develop and maintain a program to inform retailers about the methamphetamine problem in New York state.

§ 3385. Enforcement. 1. (a) The department and its representatives shall have access during business hours to all orders, prescriptions or records required to be kept under this article.

(b) Orders, prescriptions and records required to be kept under this article shall be maintained at the premises where the licensed activity is conducted.

2. For the purposes of enforcing the provisions of this article, each employee of the department designated by the commissioner shall possess all of the powers of a peace officer as set forth in section 2.20 of the criminal procedure law.

§ 3385-a. Access to criminal history information. Upon such terms and conditions as the commissioner of the division of criminal justice services agrees, authorized employees of the department's bureau of narcotic enforcement, designated by the commissioner pursuant to subdivision two of section three thousand three hundred eighty-five of this title, may access criminal history information in the central data facility established pursuant to subdivision six of section eight

hundred thirty-seven of the executive law upon request to the director of the bureau of narcotic enforcement demonstrating the necessity for such access as part of an identified, ongoing criminal investigation. Any information obtained as a result of such access shall not be disseminated to persons not authorized to access such criminal history information.

§ 3387. Seizure and forfeiture of controlled substances, imitation controlled substances and official New York state prescription forms; disposition. 1. Any controlled substance or imitation controlled substance which has been manufactured, distributed, dispensed or acquired in violation of this article, or the lawful possession of which cannot be immediately ascertained, and any official New York state prescription form which has been printed, distributed or acquired in violation of this article or the lawful possession of which cannot be immediately ascertained are hereby declared to be public nuisances and may be seized by a peace officer, acting pursuant to his special duties, or a police officer and shall be forfeited, and disposed of as follows:

(a) except as in this section otherwise provided, the commissioner, the court or magistrate having jurisdiction shall order such controlled substance or imitation controlled substance forfeited or destroyed. A record of the quantity and nature of the substance, of the place where said substance was seized, and of the time, place and manner of destruction, shall be kept, and a return under oath, reporting said destruction, shall be made to the person ordering such destruction by the officer who destroys them;

(b) upon written application by the commissioner, the court or magistrate by whom the forfeiture of controlled substances or imitation controlled substances has been decreed may order the delivery of any of them, except substances listed in schedule I of section thirty-three hundred six, to such commissioner for distribution or destruction, as hereinafter provided;

(c) upon application by any hospital within this state, not operated for private gain, the commissioner may in his discretion deliver any controlled substance or imitation controlled substance that has come into his custody by authority of this section to the applicants for

medicinal use;

(d) the commissioner may from time to time deliver excess stocks of controlled substances or imitation controlled substances to the Bureau or shall destroy the same;

(e) controlled substances or imitation controlled substances which are excess or undesired by persons lawfully possessing the same may be disposed of in such manner as the commissioner shall by regulation require;

(f) official New York state prescription forms which have been seized as provided by this section shall be disposed of by express prepaid shipment to the "State Department of Health, Bureau of Prescription Analysis, Albany, New York," or by delivery to an authorized narcotic control representative of the department.

2. The commissioner shall keep a full and complete record of all controlled substances or imitation controlled substances received and of all controlled substances or imitation controlled substances disposed of, showing the exact kinds, quantities and forms of such substances; the persons from whom received and to whom delivered; by whose authority received, delivered and destroyed; and the dates of the receipt, disposal or destruction. This record shall be open to inspection by all federal or state officers charged with the enforcement of federal and state laws relating to controlled substances or imitation controlled substances.

3. Any raw material product, container or equipment of any kind which is used, or intended for use, in manufacturing, distributing, dispensing or administering a controlled substance or imitation controlled substance in violation of this article shall be seized by any peace officer, acting pursuant to his special duties, or police officer and forfeited in the same manner as property subject to seizure and forfeiture pursuant to section thirty-three hundred eighty-eight of this article, except that such property shall not be retained for use by any official.

§ 3388. Seizure and forfeiture of vehicles, vessels or aircraft

unlawfully used to conceal, convey or transport controlled substances.

1. Except as authorized in this article, it shall be unlawful to:

(a) transport, carry, or convey any controlled substance in, upon, or by means of any vehicle, vessel or aircraft; or

(b) conceal or possess any controlled substance in or upon any vehicle, vessel or aircraft, or upon the person of anyone in or upon any vehicle, vessel or aircraft; or

(c) use any vehicle, vessel or aircraft to facilitate the transportation, carriage, conveyance, concealment, receipt, possession, purchase, or sale of any controlled substance.

2. Any vehicle, vessel or aircraft which has been or is being used in violation of subdivision one, except a vehicle, vessel or aircraft used by any person as a common carrier in the transaction of business as such common carrier shall be seized by any peace officer, acting pursuant to his special duties, or police officer, and forfeited as hereinafter in this section provided. A vehicle, vessel or aircraft is not subject to forfeiture unless used in connection with acts or conduct which would constitute a felony under article 220 of the penal law.

3. The seized property shall be delivered by the officer having made the seizure to the custody of the district attorney of the county wherein the seizure was made, except that in the cities of New York, Yonkers, Rochester and Buffalo the seized property shall be delivered to the custody of the police department of such cities and such property seized by a member or members of the state police shall be delivered to the custody of the superintendent of state police, together with a report of all the facts and circumstances of the seizure.

4. It shall be the duty of the attorney general in seizures by members of the state police, otherwise it shall be the duty of the district attorney of the county wherein the seizure is made, if elsewhere than in the cities of New York, Yonkers, Rochester or Buffalo, and where the seizure is made in such cities it shall be the duty of the corporation counsel of the city, to inquire into the facts of the seizure so reported to him and if it appears probable that a forfeiture has been incurred by reason of a violation of this section, for the determination

of which the institution of proceedings in the supreme court is necessary, to cause the proper proceedings to be commenced and prosecuted, not later than twenty days after written demand by a person claiming ownership thereof, to declare such forfeiture, unless, upon inquiry and examination, such district attorney, attorney general or corporation counsel decides that such proceedings cannot probably be sustained or that the ends of public justice do not require that they should be instituted or prosecuted, in which case, the district attorney, the attorney general or corporation counsel shall cause such seized property to be returned to the owner thereof. The procedure for proceedings instituted under this section shall conform as much as possible to the procedure for attachment.

5. Notice of the institution of the forfeiture proceeding shall be served either:

- (a) personally on the owners of the seized property; or
- (b) by registered mail to the owners' last known address and by publication of the notice once a week for two successive weeks in a newspaper published or circulated in the county wherein the seizure was made.

6. Forfeiture shall not be adjudged where the owners establish by preponderance of the evidence that:

- (a) the use of such seized property, in violation of subdivision one of this section, was not intentional on the part of any owner; or
- (b) said seized property was used in violation of subdivision one of this section by any person other than an owner thereof, while such seized property was unlawfully in the possession of a person who acquired possession thereof in violation of the criminal laws of the United States, or of any state.

7. The district attorney, the superintendent of state police or the police department having custody of the seized property, after such judicial determination of forfeiture, shall, at their discretion, either retain such seized property for the official use of their office, division or department, or, by a public notice of at least five days, sell such forfeited property at public sale; provided, however, that

where such property is subject to a perfected lien such property may not be retained for their official use unless all such liens on the property to be retained have been or will be satisfied. The net proceeds of any such sale, after deduction of the lawful expenses incurred, shall be paid into the general fund of the county wherein the seizure was made except that the net proceeds of the sale of property seized in the cities of New York, Yonkers, Rochester and Buffalo shall be paid into the respective general funds of such cities, and of the sale of property seized by the state police into the general fund of the state.

8. Whenever any person interested in any property which is seized and declared forfeited under the provisions of this section files with a justice of the supreme court a petition for the recovery of such forfeited property, the justice of the supreme court may restore said forfeited property upon such terms and conditions as he deems reasonable and just, if the petitioner establishes either of the affirmative defenses set forth in subdivision six of this section and that the petitioner was without personal or actual knowledge of the forfeiture proceeding. If the petition be filed after the sale of the forfeited property, any judgment in favor of the petitioner shall be limited to the net proceeds of such sale, after deduction of the lawful expenses and costs incurred by the district attorney, police department or corporation counsel.

9. No suit or action under this section for wrongful seizure shall be instituted unless such suit or action is commenced within two years after the time when the property was seized.

§ 3390. Revocation of licenses and certificates of approval. Any license or certificate of approval granted pursuant to this article may be revoked by the commissioner in whole or in part upon a finding that the licensee or certificate holder has:

1. falsified any application, report, or record required by this article;

2. wilfully failed to furnish the department with timely reports or information required to be filed with the department;

3. been convicted of an offense in any jurisdiction relating to any substance listed in this article as a controlled substance;

4. wilfully or negligently failed to comply with any of the provisions of the federal controlled substances act, this article, or the regulations promulgated thereunder;

5. failed to maintain effective control against diversion of controlled substances; or

6. wilfully and unreasonably refused to permit an inspection authorized by this article.

§ 3391. Revocation and suspension of license or certificate of approval procedure. 1. A proceeding to revoke a license or certificate of approval shall be commenced by a notice served personally or by registered or certified mail upon the licensee or holder of a certificate of approval directing him to show cause why his license or certificate should not be revoked. Such notice shall set forth in detail the grounds for the proposed revocation and shall fix a date for hearing not less than fifteen nor more than thirty days from the date of such notice.

2. Simultaneous with the commencement of a proceeding to revoke a license or certificate or during the course of such proceeding, the commissioner may in the case of a clear and imminent danger to the public health or safety forthwith suspend without prior notice any license or certificate theretofore issued.

3. If the commissioner suspends or revokes a license or certificate, all controlled substances owned or possessed by the licensee or holder of a certificate of approval and in the state of New York at the time of the suspension or the effective date of the revocation and which such

licensee or holder of a certificate of approval is no longer authorized to possess, shall be seized or placed under seal in the manner provided in this article.

4. In lieu of revocation of a license or certificate, the commissioner may impose a civil penalty not in excess of ten thousand dollars. Such penalty may be imposed in lieu of revocation only if the commissioner is satisfied that the imposition and payment of such penalty will serve as a sufficient deterrent to future violations.

§ 3393. Formal hearings procedure. 1. The commissioner or any person designated by him for this purpose, shall have the power to administer oaths, compel the attendance of witnesses and the production of books, records and documents and to take proof and testimony concerning all matters within the jurisdiction of the department.

2. Notice of hearing shall be served at least fifteen days prior to the date of the hearing, provided, however, whenever the commissioner has made a preliminary order suspending a license or directing the cessation of any activity pending the hearing, the commissioner shall provide the person affected thereby with an opportunity to be heard within five days.

3. At a hearing any person who is a party thereto may appear personally, shall have the right of counsel, and may cross-examine witnesses and produce evidence and witnesses in his own behalf.

4. Following a hearing, the commissioner shall make appropriate findings of fact and determinations and shall issue an order in accordance therewith.

5. The person conducting the hearing shall not be bound by the rules of evidence but any determination must be founded upon sufficient legal evidence to sustain it.

6. The commissioner may adopt such rules and regulations governing the

procedures to be followed with respect to the hearings as may be consistent with the fair and effective administration of this article.

7. Any notice, application, order or other paper required to be served upon any party to a proceeding hereunder may be served in person, by registered mail or by certified mail upon either the party or an attorney who has appeared on his behalf.

§ 3394. Judicial review. 1. All orders or determinations hereunder shall be subject to judicial review as provided in article seventy-eight of the civil practice law and rules. In any such proceeding findings of fact made by the commissioner, if supported by substantial evidence, shall be conclusive.

2. Application for such review must be made within sixty days after service of the order or determination upon the person whose license, certificate, right or privilege is affected thereby or upon the attorney of record for such person.

3. An order, or the enforcement of an order revoking or suspending a license or revoking or cancelling official forms issued by the department, if accompanied by a finding of a clear and imminent danger to the public health or safety, may not be temporarily stayed or restrained prior to a determination on the merits of the application for judicial review.

§ 3396. Violations; penalties. 1. In any civil, criminal or administrative action or proceeding brought for the enforcement of any provision of this article, it shall not be necessary to negate or disprove any exception, excuse, proviso or exemption contained in this article, and the burden of proof of any such exception, excuse, proviso, or exemption shall be upon the person claiming its benefit.

2. Violation of any provision of this article for which a penalty is specifically provided herein shall be punishable as provided herein.

Violation of any provision of this article for which no penalty is provided herein shall be punishable as provided in section twelve-b of article one of this chapter or in the penal law.

3. No person shall be prosecuted for a violation of any provision of this article if such person has been acquitted or convicted under the federal controlled substances act, of the same act or omission which, it is alleged, constitutes a violation of this article.

4. Upon the conviction of any person for violating any provision of this article, a copy of the judgment and sentence, and of the opinion of the court or judge, if any opinion be filed, shall be sent by the clerk of the court, or by the judge, to the board or officer, if any, by whom the convicted defendant has been licensed or registered to practice his profession, or to carry on his business.

5. Upon the imposition of any penalty, warning, reprimand or other sanction against any person for violating any provision of this article, a copy of the order, finding or opinion, if any is made or rendered, shall be sent by the person authorized by law to make such determination, to the board or officer by whom the respondent is licensed or registered to practice a profession or to carry on a business.

§ 3397. Fraud and deceit. 1. No person shall:

(a) obtain or attempt to obtain a controlled substance, a prescription for a controlled substance or an official New York State prescription form,

(i) by fraud, deceit, misrepresentation or subterfuge; or

(ii) by the concealment of a material fact; or

(iii) by the use of a false name or the giving of a false address;

(b) wilfully make a false statement in any prescription, order, application, report or record required by this article;

(c) falsely assume the title of, or represent himself to be a licensed manufacturer, distributor, pharmacy, pharmacist, practitioner, researcher, approved institutional dispenser, owner or employee of a

registered outsourcing facility or other authorized person, for the purpose of obtaining a controlled substance;

(d) make or utter any false or forged prescription or false or forged written order;

(e) affix any false or forged label to a package or receptacle containing controlled substances; or

(f) imprint on or affix to any controlled substance a false or forged code number or symbol.

2. Possession of a false or forged prescription for a controlled substance by any person other than a pharmacist in the lawful pursuance of his profession shall be presumptive evidence of his intent to use the same for the purpose of illegally obtaining a controlled substance.

3. Possession of a blank official New York state prescription form by any person to whom it was not lawfully issued shall be presumptive evidence of such person's intent to use same for the purpose of illegally obtaining a controlled substance.

4. Any person who, in the course of treatment, is supplied with a controlled substance or a prescription therefor by one practitioner and who, without disclosing the fact, is supplied during such treatment with a controlled substance or a prescription therefor by another practitioner shall be guilty of a violation of this article.

* ARTICLE 33-A

CONTROLLED SUBSTANCES THERAPEUTIC RESEARCH ACT

Section 3397-a. Legislative findings.

3397-b. Definitions.

3397-c. Antonio G. Olivieri controlled substances therapeutic research program established; participation.

3397-d. State patient qualification review board; composition; powers and duties.

3397-e. Patient participation in program; procedure.

3397-f. Antonio G. Olivieri controlled substances therapeutic research program; distribution.

* NB Repealed May 20, 2026

* **§ 3397-a. Legislative findings.** The legislature finds that recent research has shown that the use of marijuana may alleviate the nausea and ill-effects of cancer chemotherapy, may alleviate the ill-effects of glaucoma and may have other therapeutic uses. The legislature further finds that there is a need for further research and experimentation with regard to the use of marijuana for therapeutic purposes under strictly controlled circumstances. It is for such research programs that the controlled substances therapeutic research act is hereby enacted.

* NB Repealed May 20, 2026

* **§ 3397-b. Definitions.** As used in this article:

1. "Cannabis" means cannabis as defined in section 222.00 of the penal law and shall also include tetrahydrocannabinols or a chemical derivative of tetrahydrocannabinol.

2. "Physician" means a person licensed to practice medicine in the state of New York including a person authorized to practice medicine in a federal medical facility in the state.

3. "Hospital" means a hospital as defined in section twenty-eight hundred one of this chapter.

* NB Repealed May 20, 2026

* **§ 3397-c. Antonio G. Olivieri controlled substances therapeutic research program established; participation.** 1. The Antonio G. Olivieri controlled substances therapeutic research program is hereby established in the department of health. The commissioner shall promulgate rules and regulations necessary for the proper administration of the controlled substances therapeutic research act. In such promulgation, the commissioner shall take into consideration those pertinent rules and regulations promulgated by the drug enforcement administration, food and

drug administration and the national institute on drug abuse.

2. Participation in the Antonio G. Olivieri controlled substances therapeutic research program shall be limited to cancer patients, glaucoma patients and patients afflicted with other diseases as such diseases are approved by the commissioner. Such patient shall be certified by a physician to and approved by a patient qualification review board or committee in the manner provided by this article. Physician certification and board or committee approval shall be limited to such patients who are involved in a life-threatening or sense-threatening situation. Patients seeking participation in such program may seek the advice and shall be entitled to be advised by appropriate medical personnel concerning the medical efficacy of treatment with conventional controlled substances.

3. The commissioner, on behalf of the department, shall apply to the food and drug administration for an investigational new drug permit within ninety days after the effective date of this section.

* NB Repealed May 20, 2026

*** § 3397-d. State patient qualification review board; composition; powers and duties.** 1. The commissioner shall appoint a state patient qualification review board of no less than three nor more than five members. The state patient qualification review board shall be comprised of:

(a) A physician licensed to practice medicine in New York and certified by the American board of ophthalmology;

(b) A physician licensed to practice medicine in New York and certified by the American board of internal medicine and also certified in the subspecialty of medical oncology;

(c) A physician licensed to practice medicine in New York and certified in psychiatry by the American board of psychiatry and neurology; and

(d) Any other members that the commissioner may deem necessary.

2. Members of such board shall be appointed for three year terms

except that the term of those first appointed shall be arranged so that as nearly as possible an equal number shall terminate annually. A vacancy occurring during a term shall be filled by an appointment by the commissioner for the unexpired term. The commissioner shall designate the chairman of the board. Any member may be removed from the board at the pleasure of the commissioner.

3. Each member of the board shall receive up to one hundred fifty dollars as prescribed by the commissioner for each day devoted to board work not to exceed forty-five hundred dollars in any one year, and shall be reimbursed for necessary expenses.

* NB Repealed May 20, 2026

*** § 3397-e. Patient participation in program; procedure.** 1. Any hospital may establish a hospital patient qualification review committee subject to the rules and regulations promulgated by the commissioner. A hospital may designate a hospital human research review committee as set forth in section twenty-four hundred forty-four of this chapter to serve as a hospital patient qualification review committee.

2. Any physician may recommend a patient for participation in the Antonio G. Olivieri controlled substances therapeutic research program to the hospital patient qualification review committee for the hospital wherein such patient has received medical treatment.

3. The hospital patient qualification review committee shall review each recommendation and shall submit approved patient applications to the state patient qualification review board.

4. The state patient qualification review board shall review all physician applicants for the Antonio G. Olivieri controlled substances therapeutic research program and certify or refuse to certify their participation in the program.

5. The state patient qualification review board may delegate to a hospital patient qualification review committee the authority to approve

or disapprove a patient's participation in such program.

6. A patient shall not be eligible to participate in such program without the approval of the state patient qualification review board or the hospital patient qualification review committee delegated pursuant to subdivision five of this section.

7. The hospital human research review committee shall review each human research project proposed hereunder and shall certify to the hospital patient qualification review committee that such project meets the requirements of this article and article twenty-four-A of this chapter.

* NB Repealed May 20, 2026

* **§ 3397-f. Antonio G. Olivieri** controlled substances therapeutic research program; distribution. 1. The commissioner shall obtain marijuana through whatever means he deems most appropriate, consistent with regulations promulgated by the national institute on drug abuse, the food and drug administration and the drug enforcement administration and pursuant to the provisions of this article.

2. If, within a reasonable time, the commissioner is unable to obtain controlled substances pursuant to subdivision one of this section, he shall conduct an inventory of available sources of such drugs, including but not limited to the New York state police bureau of criminal investigation and local law enforcement officials. Said inventory shall be for the purpose of determining the feasibility of obtaining controlled substances for use in the program. Upon conducting said inventory, the commissioner shall contract with the available source for the receipt of controlled substances.

3. The commissioner shall cause such marijuana to be transferred to a hospital for distribution to the certified patient pursuant to this article.

* NB Repealed May 20, 2026

* ARTICLE 33-B

REGULATION OF CANNABINOID HEMP AND HEMP EXTRACT

Section 3398. Definitions.

- 3398-a. Rulemaking authority.
- 3398-b. Cannabinoid hemp processor license.
- 3398-c. Cannabinoid hemp retailer license.
- 3398-d. Cannabinoid license applications.
- 3398-e. Information to be requested in applications for licenses.
- 3398-f. Fees.
- 3398-g. Selection criteria.
- 3398-h. License renewal.
- 3398-i. Form of license.
- 3398-j. Transferability; amendment to license; change in ownership or control.
- 3398-k. Granting, suspending or revoking licenses.
- 3398-l. Record keeping and tracking.
- 3398-m. Packaging and labeling of cannabinoid hemp and hemp extract.
- 3398-n. Processing of cannabinoid hemp and hemp extract.
- 3398-o. Laboratory testing.
- 3398-p. New York hemp product.
- 3398-q. Penalties.
- 3398-r. Hemp workgroup.
- 3398-s. Prohibitions.
- 3398-t. Special use permits.
- 3398-u. Severability.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398. Definitions.** As used in this article, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Cannabinoid" means the phytocannabinoids found in hemp and does

not include synthetic cannabinoids as that term is defined in subdivision (g) of schedule I of section thirty-three hundred six of this chapter.

2. "Cannabinoid hemp" means any hemp and any product processed or derived from hemp, that is used for human consumption provided that when such product is packaged or offered for retail sale to a consumer, it shall not have a concentration of more than three tenths of a percent delta-9 tetrahydrocannabinol.

3. "Used for human consumption" means intended by the manufacturer or distributor to be: (a) used for human consumption for its cannabinoid content; or (b) used in, on or by the human body for its cannabinoid content.

4. "Hemp" means the plant *Cannabis sativa* L. and any part of such plant, including the seeds thereof and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 tetrahydrocannabinol concentration (THC) of not more than three-tenths of a percent on a dry weight basis. It shall not include "medical marihuana" as defined in subdivision eight of section thirty-three hundred sixty of this chapter.

5. "Hemp extract" means all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers derived from hemp, used or intended for human consumption, for its cannabinoid content, with a delta-9 tetrahydrocannabinol concentration of not more than an amount determined by the department in regulation. For the purpose of this article, hemp extract excludes (a) any food, food ingredient or food additive that is generally recognized as safe pursuant to federal law; or (b) any hemp extract that is not used for human consumption. Such excluded substances shall not be regulated pursuant to the provisions of this article but are subject to other provisions of applicable state law, rules and regulations.

6. "License" means a license issued pursuant to this article.

7. "Cannabinoid hemp processor license" means a license granted by the department to process, extract, pack or manufacture cannabinoid hemp or hemp extract into products, whether in intermediate or final form, used for human consumption.

8. "Processing" means extracting, preparing, treating, modifying, compounding, manufacturing or otherwise manipulating cannabinoid hemp to concentrate or extract its cannabinoids, or creating product, whether in intermediate or final form, used for human consumption. For purposes of this article, processing does not include: (a) growing, cultivation, cloning, harvesting, drying, curing, grinding or trimming when authorized pursuant to article twenty-nine of the agriculture and markets law; or

(b) mere transportation, such as by common carrier or another entity or individual.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-a. Rulemaking authority.** The commissioner may make regulations pursuant to this article for the processing, distribution, marketing, transportation and sale of cannabinoid hemp and hemp extracts used for human consumption, which may include, but not be limited to:

1. Specifying forms, establishing application, reasonable administration and renewal fees, or license duration;

2. Establishing the qualifications and criteria for licensing, as authorized by law;

3. The books and records to be created and maintained by licensees and lawful procedures for their inspection;

4. Any reporting requirements;

5. Methods and standards of processing, labeling, packaging and marketing of cannabinoid hemp, hemp extract and products derived

therefrom;

6. Procedures for how cannabinoid hemp, hemp extract or ingredients, additives, or products derived therefrom can be deemed as acceptable for sale in the state;

7. Provisions governing the modes and forms of administration, including inhalation;

8. Procedures for determining whether cannabinoid hemp, hemp extract or ingredients, additives, or products derived therefrom produced outside the state or within the state meet the standards and requirements of this article and can therefore be sold within the state;

9. Procedures for the granting, cancellation, revocation or suspension of licenses, consistent with the state administrative procedures act;

10. Restrictions governing the advertising and marketing of cannabinoid hemp, hemp extract and products derived therefrom; and

11. Any other regulations necessary to implement this article.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-b. Cannabinoid hemp processor license.** 1. Persons processing cannabinoid hemp or hemp extract used for human consumption, whether in intermediate or final form, shall be required to obtain a cannabinoid hemp processor license from the department.

2. A cannabinoid hemp processor license authorizes one or more specific activities related to the processing of cannabinoid hemp into products used for human consumption, whether in intermediate or final form, and the distribution or sale thereof by the licensee. Nothing herein shall prevent a cannabinoid hemp processor from processing, extracting and processing hemp products not to be used for human consumption.

3. Persons authorized to grow hemp pursuant to article twenty-nine of the agriculture and markets law are not authorized to engage in processing of cannabinoid hemp or hemp extract without first being licensed as a cannabinoid hemp processor under this article.

4. This article shall not apply to hemp, cannabinoid hemp, hemp extracts or products derived therefrom that are not used for human consumption. This article also shall not apply to hemp, cannabinoid hemp, hemp extracts or products derived therefrom that have been deemed generally recognized as safe pursuant to federal law.

5. The commissioner shall have the authority to set reasonable fees for such license, to limit the activities permitted by such license, to establish the period during which such license is authorized, which shall be two years or more, and to make rules and regulations necessary to implement this section.

6. Any person holding an active research partnership agreement with the department of agriculture and markets, authorizing that person to process cannabinoid hemp, shall be awarded licensure under this section, provided that the research partner is actively performing research pursuant to such agreement and is able to demonstrate compliance with this article, as determined by the department, after notice and an opportunity to be heard.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-c. Cannabinoid hemp retailer license.** 1. Retailers selling cannabinoid hemp, in final form to consumers within the state, shall be required to obtain a cannabinoid hemp retailer license from the department.

2. The commissioner shall have the authority to set reasonable fees for such license, to establish the period during which such license is authorized, which shall be one year or more, and to make rules and

regulations necessary to implement this section.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-d. Cannabinoid license applications.** 1. Persons shall apply for a license under this article by submitting an application upon a form supplied by the department, providing all the relevant requested information, verified by the applicant or an authorized representative of the applicant.

2. A separate license shall be required for each facility at which processing or retail sales are conducted; however, an applicant may submit one application for separate licensure at multiple locations.

3. Each applicant shall remit with its application the fee for each requested license, which shall be a reasonable fee.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-e. Information to be requested in applications for licenses.** 1. The commissioner may specify the manner and form in which an application shall be submitted to the department for licensure under this article.

2. The commissioner may adopt regulations establishing what relevant information shall be included on an application for licensure under this article. Such information may include, but is not limited to: information about the applicant's identity; ownership and investment information, including the corporate structure; evidence of good moral character; financial statements; information about the premises to be licensed; information about the activities to be licensed; and any other relevant information specified in regulation.

3. All license applications shall be signed by the applicant if an individual, by a managing partner if a limited liability company, by an

officer if a corporation, or by all partners if a partnership. Each person signing such application shall verify it as true under the penalties of perjury.

4. All license applications shall be accompanied by a check, draft or other forms of payment as the department may require or authorize in the reasonable amount required by this article for such license.

5. If there be any change, after the filing of the application or the granting, modification or renewal of a license, in any of the material facts required to be set forth in such application, a supplemental statement giving notice of such change, duly verified, shall be filed with the department within ten days after such change. Failure to do so, if willful and deliberate, may be grounds for revocation of the license.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-f. Fees.** The department may charge licensees a reasonable license fee. Such fee may be based on the activities permitted by the license, the amount of cannabinoid hemp or hemp extract to be processed or extracted by the licensee, the gross annual receipts of the licensee for the previous license period, or any other factors reasonably deemed appropriate by the department.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-g. Selection criteria.** 1. The applicant, if an individual or individuals, shall furnish evidence of the individual's good moral character, and if an entity, the applicant shall furnish evidence of the good moral character of the individuals who have or will have substantial responsibility for the licensed or authorized activity and those in control of the entity, including principals, officers, or others with such control.

2. The applicant shall furnish evidence of the applicant's experience

and competency, and that the applicant has or will have adequate facilities, equipment, process controls, and security to undertake those activities for which licensure is sought.

3. The applicant shall furnish evidence of his, her or its ability to comply with all applicable state and local laws, rules and regulations.

4. If the commissioner is not satisfied that the applicant should be issued a license, the commissioner shall notify the applicant in writing of the specific reason or reasons for denial.

5. No license pursuant to this article may be issued to an individual under the age of eighteen years.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-h. License renewal.** 1. Each license, issued pursuant to this article, may be renewed upon application therefor by the licensee and the payment of the reasonable fee for such license as specified by this article.

2. In the case of applications for renewals, the department may dispense with the requirements of such statements as it deems unnecessary in view of those contained in the application made for the original license.

3. The department shall provide an application for renewal of any license issued under this article not less than ninety days prior to the expiration of the current license.

4. The department may only issue a renewal license upon receipt of the specified renewal application and renewal fee from a licensee if, in addition to the selection criteria set out in this article, the licensee's license is not under suspension and has not been revoked.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-i. Form of license.** Licenses issued pursuant to this article shall specify:

1. The name and address of the licensee;
2. The activities permitted by the license;
3. The land, buildings and facilities that may be used for the licensed activities of the licensee;
4. A unique license number issued by the department to the licensee;
and
5. Such other information as the commissioner shall deem necessary to assure compliance with this chapter.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-j. Transferability; amendment to license; change in ownership or control.** 1. Licenses issued under this article are not transferable, absent written consent of the commissioner.

2. Upon application of a licensee, a license may be amended to add or delete permitted activities.

3. A license shall become void by a change in ownership, substantial corporate change or change of location without prior written approval of the commissioner. The commissioner may make regulations allowing for certain types of changes in ownership without the need for prior written approval.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-k. Granting, suspending or revoking licenses.** After due notice and an opportunity to be heard, established by rules and regulations, the commissioner may decline to grant a new license, impose conditions or limits with respect to the grant of a license, modify an existing license or decline to renew a license, and may suspend or revoke a license already granted after due notice and an opportunity to be heard, as established by rules and regulations, whenever the commissioner finds that:

1. A material statement contained in an application is or was false or misleading;

2. The applicant or licensee, or a person in a position of management and control thereof or of the licensed activity, does not have good moral character, necessary experience or competency, adequate facilities, equipment, process controls, or security to process, distribute, transport or sell cannabinoid hemp, hemp extract or products derived therefrom;

3. After appropriate notice and opportunity, the applicant or licensee has failed or refused to produce any records or provide any information required by this article or the regulations promulgated pursuant thereto;

4. The licensee has conducted activities outside of those activities permitted on its license; or

5. The applicant or licensee, or any officer, director, partner, or any other person exercising any position of management or control thereof or of the licensed activity has willfully failed to comply with any of the provisions of this article or regulations under it and other laws of this state applicable to the licensed activity.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-l. Record keeping and tracking.** Every licensee shall keep, in

such form as the commissioner may direct, such relevant records as may be required pursuant to regulations under this article.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-m. Packaging and labeling of cannabinoid hemp and hemp extract.** 1. Cannabinoid hemp processors shall be required to provide appropriate label warning to consumers, and restricted from making unapproved label claims, as determined by the department, concerning the potential impact on or benefit to human health resulting from the use of cannabinoid hemp, hemp extract and products derived therefrom for human consumption, which labels shall be affixed to those products when sold, pursuant to rules and regulations that the department may adopt.

2. The department may, by rules and regulations, require processors to establish a code, including, but not limited to QR code, for labels and establish methods and procedures for determining, among other things, serving sizes or dosages for cannabinoid hemp, hemp extract and products derived therefrom, active cannabinoid concentration per serving size, number of servings per container, and the growing region, state or country of origin if not from the United States. Such rules and regulations may require an appropriate fact panel that incorporates data regarding serving sizes and potency thereof.

3. The packaging, sale, or possession of products derived from cannabinoid hemp or hemp extract used for human consumption not labeled or offered in conformity with regulations under this section shall be grounds for the seizure or quarantine of the product, the imposition of a civil penalty against a processor or retailer, and the suspension, revocation or cancellation of a license, in accordance with this article.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-n. Processing of cannabinoid hemp and hemp extract.** 1. No

processor shall sell or agree to sell or deliver in the state any cannabinoid hemp, hemp extract or product derived therefrom, used for human consumption, except in sealed containers containing quantities in accordance with size standards pursuant to rules adopted by the commissioner. Such containers shall have affixed thereto such labels as may be required by the rules of the department.

2. Processors shall take such steps necessary to ensure that the cannabinoid hemp or hemp extract used in their processing operation has only been grown with pesticides that are registered by the department of environmental conservation or that specifically meet the United States environmental protection agency registration exemption criteria for minimum risk, used in compliance with rules, regulations, standards and guidelines issued by the department of environmental conservation for pesticides.

3. All cannabinoid hemp, hemp extract and products derived therefrom used for human consumption shall be extracted and processed in accordance with good manufacturing processes pursuant to Part 117 or Part 111 of title 21 of the code of federal regulations, as may be defined, modified and decided upon by the commissioner in rules or regulations.

4. As necessary to protect human health, the department shall have the authority to: (a) regulate and prohibit specific ingredients, excipients or methods used in processing cannabinoid hemp, hemp extract and products derived therefrom; and (b) prohibit, or expressly allow, certain products or product classes derived from cannabinoid hemp or hemp extract, to be processed.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-o. Laboratory testing.** Every cannabinoid hemp processor shall contract with an independent commercial laboratory to test the hemp extract and products produced by the licensed processor. The commissioner shall establish the necessary qualifications or

certifications required for such laboratories used by licensees. The commissioner is authorized to issue rules and regulations consistent with this article establishing the testing required, the reporting of testing results and the form for reporting such laboratory testing results. The department has authority to require licensees to submit any cannabinoid hemp, hemp extract or product derived therefrom, processed or offered for sale within the state, for testing by the department. This section shall not obligate the department, in any way, to perform any testing on hemp, cannabinoid hemp, hemp extract or product derived therefrom.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-p. New York hemp product.** The commissioner may establish and adopt official grades and standards for cannabinoid hemp, hemp extract and products derived therefrom, as he or she may deem advisable, which are produced for sale in this state and, from time to time, may amend or modify such grades and standards.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-q. Penalties.** Notwithstanding the provision of any law to the contrary, the failure to comply with a requirement of this article, or a regulation thereunder, may be punishable by a civil penalty of not more than one thousand dollars for a first violation; not more than five thousand dollars for a second violation within three years; and not more than ten thousand dollars for a third violation and each subsequent violation thereafter, within three years.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-r. Hemp workgroup.** The commissioner, in consultation with the commissioner of the department of agriculture and markets, may appoint a New York state hemp and hemp extract workgroup, composed of growers,

researchers, producers, processors, manufacturers and trade associations, to make recommendations for the industrial hemp and cannabinoid hemp programs, state and federal policies and policy initiatives, and opportunities for the promotion and marketing of cannabinoid hemp and hemp extract as consistent with federal and state laws, rules and regulations.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-s. Prohibitions.** 1. Except as authorized by the United States food and drug administration, the processing of cannabinoid hemp or hemp extract used for human consumption is prohibited within the state unless the processor is licensed under this article.

2. Cannabinoid hemp and hemp extracts used for human consumption and grown or processed outside the state shall not be distributed or sold at retail within the state, unless they meet all standards established for cannabinoid hemp under state law and regulations.

3. The retail sale of cannabinoid hemp is prohibited in this state unless the retailer is licensed under this article.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

*** § 3398-t. Special use permits.** The commissioner shall have the authority to issue temporary permits for carrying on any activity related to cannabinoid hemp, hemp extract and products derived therefrom, licensed under this article. The commissioner may set reasonable fees for such permits, to establish the periods during which such permits are valid, and to make rules and regulations to implement this section.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

* **§ 3398-u. Severability.** If any provision of this article or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this article which can be given effect without the invalid provision or application, and to this end the provisions of this article are declared to be severable.

* NB Repealed 6 months after the full cannabis control board created by Article 2 of the cannabis law has been appointed

ARTICLE 34

FUNERAL DIRECTING

- Title I. General provisions (Secs. 3400-3404).
II. Licensing and registration (Secs. 3420-3429).
III. Practice of funeral directing; funeral establishments (Secs. 3440-3444).
IV. Enforcement and discipline; violations and penalties (Secs. 3450-3457).

TITLE I

GENERAL PROVISIONS

- Section 3400. Funeral directing; definitions.
3401. Funeral directing; powers and duties of commissioner.
3402. Funeral directing advisory board.
3403. Funeral directing; fees; fines; penalties; dispositions.
3404. Construction; inconsistent provisions of other laws.

§ 3400. Funeral directing; definitions. As used in this article, unless otherwise stated, the following terms shall have the respective meanings hereinafter set forth or indicated:

(a) "Funeral director" means a person to whom a valid license as such has been duly issued.

(b) "Undertaker" means a person to whom a valid license as such has been duly issued.

(c) "Embalmer" means a person to whom a valid license as such has been

duly issued.

(d) "Funeral directing" means the care and disposal of the body of a deceased person and/or the preserving, disinfecting and preparing by embalming or otherwise, the body of a deceased person for funeral services, transportation, burial or cremation; and/or funeral directing or embalming as presently known whether under these titles or designations or otherwise.

(e) "Undertaking" means the care, disposal, transportation, burial or cremation by any means other than embalming of the body of a deceased person.

(f) "Embalming" means preparing, disinfecting and preserving, either hypodermically, arterially or by any other recognized means the body of a deceased person for burial, cremation or other final disposition.

(g) "Funeral establishment" means a single physical location, address or premises devoted to or used for the care and preparation of a body of a deceased person for disposition and for mourning or funeral ceremonial purposes.

(h) "Burial" includes transportation and/or cremation.

(i) "Advertisement" means the publication, dissemination, circulation, or placing before the public, or causing directly or indirectly to be made, published, disseminated, or placed before the public, any announcement or statement in a newspaper, magazine, or other publication, or in the form of a book, notice, circular, pamphlet, letter, hand-bill, poster, bill, sign, placard, card, label, tag, or by radio or television or any other means.

(j) "Funeral firm" means an individual, partnership, corporation or estate representative engaged in the business and practice of funeral directing.

(k) "Registered resident" means a person who passed a funeral directing examination and who is duly registered as such with the department while in the employ of a registered funeral firm and who is engaged in the practice of funeral directing under the supervision of a licensed funeral director or undertaker and embalmer; provided, however, that a registered resident shall not have authority to sign any form or document required by law which requires the signature of a licensed funeral director or make funeral arrangements or own or manage a funeral firm.

(l) "Embalming fluid" means any chemicals or substances manufactured primarily for use by licensed funeral directors, undertakers or embalmers, or registered residents, to prepare, disinfect or preserve, either hypodermically, arterially or by any other recognized means the body of a deceased person for burial, cremation or other final disposition.

§ 3401. Funeral directing; powers and duties of commissioner. 1. The commissioner may, from time to time, make and adopt such rules and regulations not inconsistent with law as may be necessary (a) in the performance of his duties and in the administration of the provisions of this article; and (b) to govern and regulate the conduct and transaction of the business and practice of funeral directing, undertaking and embalming.

2. The commissioner shall:

(a) ascertain what constitutes the best tests for determining whether life is extinct, and shall prescribe the application of such tests, as he may deem necessary;

(b) investigate all alleged violations of law and of all rules and regulations relating to funeral directing, undertaking, and embalming;

(c) appoint such personnel as he may deem necessary, who, subject to the supervision, direction, and control of the commissioner, shall exercise the powers and perform the duties of the department and advise the commissioner under this article.

§ 3402. Funeral directing advisory board. 1. There shall be in the department a funeral directing advisory board consisting of ten members who shall be appointed by the commissioner of health of whom three shall be representatives of consumer interests, having no pecuniary interest, affiliation or other association, direct or indirect, other than as consumers, with any business affecting the disposal or burial of deceased human beings, as the commissioner shall determine, six shall be licensed funeral directors, undertakers or embalmers in this state, having been actually engaged in the practice of funeral directing,

undertaking or embalming, as the case may be, for at least five years prior to appointment and one member shall be an officer, director or employee of a cemetery corporation. The term of each member of such advisory board shall be three years, or until a successor is appointed, and vacancies shall be filled for the unexpired term only. The commissioner of health may remove any member of the board for misconduct, incompetence or neglect of duty after such member shall have been given a written statement of the charges and an opportunity to be heard thereon.

2. The board shall elect annually from its members a chairman and vice-chairman and for the purpose of transacting its business shall meet at least once every three months. Special meetings also may be held as frequently as its business may require at the call of the chairman upon the request of a majority of the members of the board or as requested by the commissioner of health. Written notice of the time, place and purpose of meetings shall be mailed by the secretary to all members at least ten days before the date of the meeting. A quorum of the board shall consist of not less than six members.

3. Members of the advisory board shall receive no compensation, but each shall be entitled to receive his reasonable expenses actually and necessarily incurred in the performance of his duties.

4. The commissioner shall designate an officer or employee of the department to act as secretary of the board, who shall not be a member of the board and who shall not receive any additional compensation therefor.

5. The commissioner shall request the advisory board to, and upon such request the advisory board shall, or upon its initiative the advisory board may

(a) consider any matters relating to the practice of funeral directing, undertaking or embalming, including any matter pertaining to the administration and enforcement of this article and advise the commissioner thereon;

(b) recommend to the commissioner the establishment of such laws as

may be deemed necessary in respect to the practice of funeral directing;

(c) recommend to the commissioner the promulgation of rules and regulations not inconsistent with law, as may be deemed necessary, and the amendment or repeal thereof;

(d) recommend to the commissioner the commencement of any investigation into improper practices of licensees;

(e) report, within forty-five days after receipt, on any proposed regulations, amendments thereto, or repeal thereof, prior to action thereon by the commissioner;

(f) review the applications for registration of candidates for either practical or academic training and make recommendations to the commissioner for the acceptance or rejection thereof.

(g) delegate one member of the board to attend any formal disciplinary hearing and subsequent proceedings involving an alleged violation of this article. The board shall not delegate a member who practices funeral directing, embalming or undertaking in the same judicial district as an accused licensee.

6. The advisory board shall have no executive, administrative or appointive powers or duties.

§ 3403. Funeral directing; fees; fines; penalties; dispositions. 1.

All fees, fines, penalties and other moneys derived from the operation of this article or rules promulgated pursuant thereto shall be paid to the department and on the fifth day of each month shall be paid by the department to the state treasury.

2. Moneys received pursuant to this article may be refunded to the applicant on proof satisfactory to the commissioner that:

(a) such moneys were in excess of the amounts required by law;

(b) examination for which application has been made and for which fee has been paid was denied;

(c) the individual, corporation, or association which applied for registration or license has ceased business prior to commencement of the period of such registration or license because of death, dissolution, or removal from the state.

3. (a) All licensing and registration fees collected pursuant to this article shall be deposited into the miscellaneous special revenue fund - 339, the funeral directing program account, which is hereby established.

(b) Monies available in the funeral directing program account shall be used to support the department's activities relating to ensuring compliance with the provisions of this chapter as they relate to the practice of funeral directing.

§ 3404. Construction; inconsistent provisions of other laws. The provisions of this article shall supersede any inconsistent provisions of any general, special, or local law.

TITLE II

LICENSING AND REGISTRATION

- Section 3420. Funeral directing; license to practice required; exceptions.
3421. Funeral directing; requirements for license to practice.
3422. Funeral directing; licensing examinations; content; procedure.
3423. Funeral directing; undertakers and embalmers; requirements for license to practice; examinations.
3424. Funeral directing; reports by trainees, employees and schools.
3425. Funeral directing; schools; approval.
3426. Funeral directing; licensing reciprocity with other states.
3427. Funeral directing; issuance of duplicate licenses.
3428. Funeral directing; registration of licenses; fees.
3429. Continuing education for funeral directors.

§ 3420. Funeral directing; license to practice required; exceptions.

1. No person shall engage in the business or practice of funeral directing, undertaking, or embalming or transact or hold himself out as

transacting or practicing or as being entitled to transact or practice funeral directing, undertaking or embalming in this state unless duly licensed according to law, and registered under the provisions of this article, except that nothing in this article contained shall prohibit embalming:

(a) by commissioned medical officers in the armed forces of the United States or in the United States public health service while on active duty in the respective service; or,

(b) by any one actually serving as a member of the resident medical staff of any legally incorporated hospital; or,

(c) by any person duly licensed to practice as a physician or surgeon in this state.

2. A person who holds a license as a funeral director, undertaker or embalmer, as defined herein, and is registered as required herein, shall be entitled to practice as defined and limited by the provisions of the law at the time the license was issued, except as otherwise provided by this article.

3. Notwithstanding the foregoing provisions of this section, the commissioner may in his discretion enter into an agreement with another state of the United States or a province of the Dominion of Canada, pursuant to which agreement any person, duly licensed and registered as a funeral director, undertaker or the equivalent thereof by and in such other state or province, may enter into this state for the sole purposes of removing to such other state or province dead human bodies, supervising the delivery to or removal from a common carrier of such bodies, or burying, cremating, or supervising funeral services over dead human bodies brought from such other state or province as though such person were duly licensed and registered by and in this state except that such person shall not maintain an establishment, advertise or hold himself out directly or through any agent or agency or otherwise as a funeral director, undertaker or the equivalent thereof other than in the state or province in which he is registered and licensed.

§ 3421. Funeral directing; requirements for license to practice. 1. In

order to be licensed, an applicant for licensure shall pass a funeral directing examination prepared or approved by the department to determine his knowledge and fitness therefor, as required by this article. No person shall be permitted to enter funeral director school, apply for a funeral directing examination or apply for a funeral directing license without submitting to the department satisfactory evidence of good moral character.

2. Except as provided in subdivision three, the department shall admit to examination any applicant who pays a fee of forty dollars and submits evidence subscribed and affirmed as true under the penalties of perjury and satisfactory to the department that the applicant:

(a) is a citizen of the United States or a noncitizen lawfully admitted for permanent residence in the United States;

(b) has satisfactorily completed a course of collegiate level study in funeral service, the curriculum of which has been approved by the department, consisting of not less than ninety quarter credits or sixty semester credits in an institution or institutions approved by the department or an accrediting agency recognized by the department;

(c) has upon entering an approved institution as herein provided for the purpose of beginning his funeral service study, registered as a student with the department upon a form to be provided by the department, and has paid to the department a registration fee of fifty dollars.

3. Delay in registering as a student as herein required may be excused, in the discretion of the commissioner.

4. The department shall issue a license to practice funeral directing to an applicant for such license on the basis of the following procedures:

(a) who shall have successfully passed the examination as herein provided in subdivision one of this section, and

(b) who pays a fee of one hundred twenty-five dollars, and

(c) who, after having passed such examination, serves a one year period as a registered resident in a manner satisfactory to the department, and

(d) who, has passed a second examination after or during the serving of a one year period as a registered resident. The said examination shall be on the New York state laws, rules and regulations relating to funeral directing and shall be prepared or approved by the department of health.

§ 3422. Funeral directing; licensing examinations; content; procedure.

1. The commissioner shall determine the subjects of examination of applicants for license to practice funeral directing, undertaking or embalming, and the scope, content and character, of such examinations which in any examination shall be the same for all candidates.

2. Examinations shall be held twice in each year.

3. A candidate who fails to attain a passing grade on his or her licensing examination is entitled to a maximum of three re-examinations; provided, however, that if such candidate fails to attain a passing grade within three years after completion of his or her training, he or she must requalify in accordance with the provisions of the public health law and rules and regulations promulgated thereunder existing and in force as of the date of subsequent application for licensing examination, except that a satisfactorily completed required course of study need not be recompleted. A candidate inducted into the armed forces of the United States during or after completion of training may (a) after honorable discharge or (b) after a discharge other than bad conduct or dishonorable where the candidate (i) has a qualifying condition, as defined in section one of the veterans' services law, or (ii) is a discharged LGBT veteran, as defined in section one of the veterans' services law, and upon proper application as required by the department be eligible for an exemption with respect to time served in such service.

4. Following the close of every written examination prepared and administered by the department the questions submitted and the answers made thereto by the applicant together with a record stating in detail the result of the examination for each candidate shall be kept by the

department for a period of one year. These may be destroyed at the end of such period.

§ 3423. Funeral directing; undertakers and embalmers; requirements for license to practice; examinations. 1. The department shall continue to hold re-examinations as may be necessary, as provided by former article fourteen of the public health law, as amended, and the rules and regulations promulgated thereunder for applicants who have prior to July first, nineteen hundred fifty-one, taken and failed to pass an examination for undertaker or embalmer license until December thirty-first, nineteen hundred sixty-three.

2. The department shall admit to such re-examinations any applicant who pays a fee of five dollars, is registered as a trainee with the department and is otherwise qualified in accordance with former article fourteen of the public health law as amended.

3. The department shall issue an undertaker or embalmer license to those who, upon payment of a fee of ten dollars, qualify in accordance with the provisions of this section, and who pass such re-examination.

4. An undertaker or embalmer license shall entitle the holders thereof to practice undertaking or embalming, respectively.

5. Any person who was a duly registered trainee on April first, nineteen hundred forty-five, and, was in the armed forces of the United States on April first, nineteen hundred forty-five, and whose training and experience shall have been interrupted by his service in the armed forces of the United States, shall be permitted to resume his training and experience at any time within one year after the date of his discharge from active service. The department shall continue to hold examinations for such candidates for undertaking and embalmer licenses and to issue such licenses as herein provided.

§ 3424. Funeral directing; reports by trainees, employees and schools.

1. Each trainee and the employer and funeral director school shall:
 - (a) maintain and file such periodic records and reports as the department shall require; and
 - (b) notify the department promptly of any change in school registration or change of employment.

§ 3425. Funeral directing; schools; approval. 1. Any school for funeral directors may apply to the commissioner for the issuance of a certificate of approval as maintaining a satisfactory standard, so that students desiring to engage in the business or practice of funeral directing in the state of New York may receive credit for attendance at such school.

2. Such application shall be made upon a form prescribed and furnished by the commissioner which shall contain such information as the commissioner may require.

3. (a) The commissioner shall cause to be made such investigation and inspection of such school as he may deem necessary, and thereafter the department shall issue a certificate of approval to each school for funeral directors approved by the department as maintaining a satisfactory standard.

(b) A certificate of approval issued under this section shall be valid for one year.

4. (a) A school for funeral directors located outside the state of New York shall pay the traveling and other expenses incurred by representatives of the department in making such investigation and inspection as the commissioner may prescribe.

(b) Each certificate of approval may be renewed for additional periods of one year.

5. The commissioner may, in lieu of the foregoing approval procedures, accept the certification of accreditation issued by an accrediting organization recognized by the department of health.

§ 3426. Funeral directing; licensing reciprocity with other states.

The commissioner, in his or her discretion, and otherwise subject to the provisions of this article and the rules of the department promulgated thereunder prescribing the qualifications for funeral director license, may endorse, without examination, a funeral director license issued by the proper authorities of any other state or political subdivision of the United States, upon payment of a fee of three hundred dollars, and upon submission of evidence satisfactory to the commissioner:

(a) that such other state or political subdivision of the United States maintains a system and standard of qualification and examination for funeral director license, which is substantially equivalent to those required in this state; and,

(b) that such other state or political subdivision of the United States gives similar recognition and endorsement to licenses of this state; and,

(c) that the applicant for such endorsement, since receiving his license from such other state or political subdivision of the United States, has been engaged in the practice of funeral directing for three years or more in one or more of the states or political subdivisions of the United States; and,

(d) that such applicant for endorsement is actually engaged in the practice of funeral directing at the time of application for endorsement and is in good and regular standing as a funeral director in each state or political subdivision of the United States from which he has ever received a funeral director license.

§ 3427. Funeral directing; issuance of duplicate licenses. Upon receipt of satisfactory evidence that a license or certificate has been lost, mutilated or destroyed, the department may issue a duplicate license or certificate upon such terms and conditions as the commissioner shall prescribe, and upon payment of a fee of twenty dollars.

§ 3428. Funeral directing; registration of licenses; fees. 1. (a)

Every person who, within the state, practices as a funeral director, undertaker or embalmer and every person, partnership or corporation who or which owns or operates within the state a funeral firm as herein defined shall biennially apply to the department for an appropriate certificate of registration and report, in a statement subscribed and affirmed as true under the penalties of perjury, any facts requested by the department.

(b) Such report by a corporation also shall set forth the name, residence address and title of each of its officers and directors and the name and residence address of each stockholder and other person, firm and corporation having a ten per centum or greater proprietary, beneficial, equitable or credit interest therein.

(c) Every such report also shall contain a statement as to whether the applicant and, if a partnership, any partner and, if a corporation, any of the officers, directors, stockholders or other persons, firms or corporations required to be listed therein had been convicted of a crime in the two year period immediately preceding the date of such application. Such statement shall identify such crime and the jurisdiction involved and the disposition of the charge.

(d) Every such report shall contain a statement as to whether the applicant and, if a partnership, any partner and, if a corporation, any of the officers, directors, stockholders or other persons, firms or corporations required to be listed therein, or any funeral firm with which such applicant, partner, officer, director, stockholder, person, firm or corporation has been affiliated, has been found in violation of the provisions of this article or any statute, rule or regulation relating to funeral directing. Such statement shall identify such statute, rule or regulation and the disposition of any proceeding thereon.

(e) In addition to such report, every person, partnership or corporation herein required to apply for a certificate shall without delay inform the department by written statement of his conviction, or of the conviction of any member of the partnership, or, if a corporation, of the conviction of any of its officers, directors, stockholders or other persons, firms or corporations required to be reported as provided by paragraph (b) of this subdivision.

(f) In addition to any report required pursuant to this section, every

person, partnership or corporation herein required to apply for a certificate of registration pursuant to this article shall provide notice to the department of the proposed: (i) sale or transfer of all or substantially all of the assets of a funeral firm, (ii) the sale or transfer of a controlling interest of such funeral firm, or (iii) the termination of the business of such funeral firm where there is no transferee of assets or stock. For purposes of this section, the term "controlling interest" shall mean a fifty-one percent interest in a partnership or fifty-one percent of the issued and outstanding shares of stock of a corporation. In the case of subparagraphs (i) and (ii) of this paragraph, such notice to the department shall identify the transferee or transferees of the assets or controlling interest and contain a listing of the names and addresses of the persons who deposited moneys with the funeral firm pursuant to section four hundred fifty-three of the general business law, and the amount to be transferred to the transferee or transferees. In the case of the termination, cessation of operation or discontinuation of the firm where there is no transferee, such notice shall contain a listing of the names and addresses of the persons who deposited funds with the funeral firm, the amount held in trust by such funeral firm and the proposed disposition of the moneys so held by such funeral firm. All such notices shall be provided to the department not less than ten days after the sale or transfer of such funeral firm or not less than thirty days prior to the termination, cessation of operation or discontinuation of the business of such funeral firm.

2. (a) An undertaker or embalmer shall pay to the department a biennial registration fee of sixty-two dollars and fifty cents.

(b) A funeral director shall pay a biennial registration fee of one hundred twenty-five dollars; however, initial registration shall not require such fee.

(c) Only a registered funeral firm may operate, or engage in the business and practice of funeral directing. Said business and practice must be conducted from an approved funeral establishment. In the event a funeral firm conducts its business from more than one funeral establishment, the firm must be registered from each such establishment. In the event more than one firm conducts its business from the same

funeral establishment, each firm must be registered from the establishment and have an individual manager representing that firm at that establishment. The initial registration fee for each required registration is four hundred dollars for the period ending with the then current biennial registration period, and the biennial registration fee thereafter is three hundred dollars.

(d) The owner of a funeral firm shall pay a registration fee of one hundred dollars for the amendment of a certificate of registration to indicate a change of location, change of manager or change in firm name thereof.

(e) For failure to register, an additional fee of ten dollars for each delay of thirty days or part thereof beyond the first day of the biennial registration period shall be added to the regular fee. The commissioner may, for good cause shown, waive or compromise all or any part of this additional fee.

3. (a) Upon verification of the statements thus reported and the receipt of the requisite fee, the commissioner shall issue a certificate of registration; except that, in those instances where a conviction shall have been reported as herein required, or upon other proof thereof, and in the case of a funeral firm where an applicant or, if a partnership, any partner or, if a corporation, any of its officers, directors, stockholders or other persons, firms or corporation required to be reported as provided by paragraph (b) of subdivision one of this section, or any funeral firm with which such applicant, partner, officer, director, stockholder, person, firm or corporation has been affiliated, has committed repeated violations of the provisions of this article or any statute, rule or regulation relating to funeral directing, or has committed a significant violation, as defined by the commissioner pursuant to rule and regulation, of the provisions of this article or any statute, rule or regulation relating to funeral directing, the commissioner may deny an application for a certificate.

(b) The commissioner shall afford the applicant an opportunity to be heard at a hearing, on due notice, conducted in accordance with the provisions of this chapter, prior to the issuance of any order or determination denying such application.

4. The commissioner shall establish by rule and regulation the beginning date of the biennial registration period. In the event that a change in the established beginning date of the biennial registration period requires an adjustment in the duration of a registration period, there shall be a proportionate adjustment in the prescribed fee.

5. Each licensee who applies for registration as a funeral director, undertaker or embalmer during the second year of a biennial registration period shall pay a fee of twenty-five dollars for funeral director registration or twelve dollars and fifty cents for undertaker registration, and twelve dollars and fifty cents for embalmer registration. However, initial registration for funeral directors shall not require such fee.

6. If any funeral director, undertaker or embalmer continues to practice, or any owner continues to operate a funeral firm, without registration, as herein provided, his license or business registration may be suspended or revoked by the department in accordance with the provisions of this article.

7. A funeral director, undertaker or embalmer who has been heretofore duly licensed and registered to practice in this state whose license shall not have been revoked or suspended, and who either before or after registration as required by this section shall have temporarily abandoned the practice of funeral directing, undertaking or embalming, or shall have removed from the state, may register within the state upon complying with the provisions of this section for registration, and also, filing with the department a statement of such facts subscribed and affirmed by him as true under the penalties of perjury.

8. Every funeral director, undertaker or embalmer shall communicate with the department in the event that the application blank for registration fails to reach them.

9. A funeral director, undertaker or embalmer who has been heretofore duly licensed and registered to practice in this state whose license shall not have been revoked or suspended and who no longer practices

funeral directing, may apply for an inactive certificate of registration. The fee for an inactive certificate of registration shall be the same amount as the regular certificate of registration. Upon complying with the provisions of this section and section three thousand four hundred twenty-nine of this title for registration, a regular certificate of registration shall be reinstated. An inactive registrant shall be considered duly licensed and registered solely for the purposes of section three thousand four hundred forty-three of this article, provided, however, that any such registrant using his or her name in any advertising or promotional materials shall disclose their inactive status in such materials.

§ 3429. Continuing education for funeral directors. 1. Definitions. As used in this section:

(a) "Biennium" means any two-year period for registration of individuals licensed to practice funeral directing or embalming in this state pursuant to section three thousand four hundred twenty-eight of this title;

(b) "Continuing education" means a course of instruction in a field of funeral directing, within the subjects listed in subdivision five of this section, taught by a provider registered with the department under subdivision four of this section;

(c) "Contact hour" means a period of between fifty and sixty minutes, continuously measured;

(d) "Provider" means a national, state or local trade association of funeral directors, a school for funeral directors approved under section three thousand four hundred twenty-five of this title or, with prior or provisional approval of course content by the department under subdivision four of this section, any other person or organization desiring to offer continuing education;

(e) "Trade association" means an organization, whether incorporated or not, whose primary class of members consists of ten or more firms under separate ownerships or twenty individuals in different employment, all registered under section three thousand four hundred twenty-eight of this title in an aspect of funeral service, which has been organized and maintained for at least two years prior to offering continuing education

under this section for the collective benefit of its members.

2. Requirement. (a) Every person who renews a certificate of registration under section three thousand four hundred twenty-eight of this title shall file with the department, along with his or her biennial application for renewal, a certification attesting to the course or programs of instruction taken and successfully completed by such person and which clearly demonstrates that the person has completed the minimum number of hours of continuing education within the current biennium as set forth in subdivision three of this section.

(b) The department shall provide a certification form which shall require the following information:

(i) Applicant's full name and registration number;

(ii) Applicant's statement that he or she attended a specified number of hours of continuing education within the current biennium, consisting of courses identified by sponsor, date, location, and length of time in hours; and

(iii) Applicant's signature and date.

(c) This subdivision shall not apply to a funeral director, undertaker or embalmer who is an inactive registrant pursuant to subdivision nine of section three thousand four hundred twenty-eight of this title.

3. Minimum hours. The minimum hours of continuing education which an individual renewing registration must complete are:

(a) to renew for the first biennium commencing on June thirtieth, two thousand two, six hours within the current biennium concluding on such date.

(b) to renew for all subsequent biennia, twelve hours within each biennium, including at least two hours relating to applicable New York state laws and regulations affecting funeral directing, embalming and preneed services, which may be provided by the department or a provider registered pursuant to the provisions of subdivision four of this section.

4. Provider registration; course content approval. (a) Any person who is a provider and who desires to offer continuing education shall first register with the department and pay a registration fee of one hundred

fifty dollars for the first biennium. A provider once registered may renew the registration for subsequent biennia for a fee of seventy-five dollars per biennium. The provider shall submit with its registration fee an affidavit which includes the following information and statements:

(i) Provider's name, address, telephone number, and, when known, names of individual instructors;

(ii) Provider's agreement to accept periodic monitoring of its courses by the department;

(iii) Provider's certification that the contents of each course are within the scope of subdivision five of this section;

(iv) Provider's commitment to verify attendance at each course and to maintain attendance records for department inspection for five years;

(v) Provider's commitment to establish a mechanism whereby licensees may evaluate the quality and content of each course taken as well as the provider's overall program when requested to do so by the department, and to maintain records of such evaluations for department inspection for five years;

(vi) Provider's agreement to submit to the department such evidence as is necessary to establish compliance with this section;

(vii) Provider's acknowledgment that disapproval by the department of a particular course or revocation of the provider's registration may result in nonrecognition of hours of continuing education from that provider; and

(viii) Provider's signature and date and verification by a notary public.

(b) A registered provider which is required to obtain prior approval of courses shall submit to the department a written description of each course for which approval is requested, at least sixty days prior to the first date the course is to be offered. If the department does not disapprove the proposed course within ninety days of its receipt of the written description and request for approval, the course shall be considered approved provisionally for six months. Following the six months of provisional approval, the department may make a final determination disapproving the course. Notwithstanding such determination, however, any individuals licensed pursuant to section three thousand four hundred twenty-eight of this title shall receive

full continuing education credit for any course taken during the period of provisional approval to fulfill the requirements of this section.

(c) Any provider registered to offer continuing education under this section shall require each person taking instruction to display or provide, prior to admission or before the initiation of any such instruction, personal photo identification in the form of an automobile driver's license, passport or any other similar form of photo identification issued by a governmental entity, or a trade association as defined in this section. The provider may allow the use of a photocopy of such identification for computer-based or distance learning instruction.

(d) The department may impose a fine of no less than the biennial registration fee upon a provider who violates the provisions of this section. For a second violation, the department may impose an additional fine of up to five hundred dollars and suspend the registration for the balance of the biennium. Nothing herein shall prevent the attorney general from bringing a civil action against any provider offering continuing education courses without the prior or provisional approval of the department.

(e) Registered provider status may be revoked by the department if the reporting requirements contained in this section are not met or, if upon review of the provider's performance, the department determines that the content of the course materials, the quality of the continuing education activities or the provider's performance does not meet the requirements set forth herein. In such event, the department shall send the provider by ordinary mail a notice of revocation. The revocation shall take effect no less than sixty days from the date such mailed revocation is postmarked. The provider may request a review of such revocation, and the department shall determine the request within thirty days. The decision of the department shall be final after such review.

(f) Section twelve of this chapter shall not apply to this section; provided, however, that any action by the department in suspending or revoking a provider registration in accordance with this subdivision shall be reviewable by the supreme court of the state of New York pursuant to the provisions of article seventy-eight of the civil practice law and rules.

5. Subjects of continuing education. The subjects of continuing education may be one or more of the following: aftercare, business administration, religion, natural sciences, management services, data processing, organ procurement, preneed services, jurisprudence (federal, state, and local), restorative arts and embalming, funeral service counseling, funeral customs, sanitation and infection control, and hospice and similar outreach programs.

6. Credit for preparation. A licensed funeral director may earn up to two hours of continuing education credit for preparing an hour of continuing education that he or she then teaches, and may earn the hour solely for teaching that material the first time. No one may earn more than six hours per biennium for preparation and teaching.

7. Classroom time; minimum percentage. A funeral director shall take at least fifty percent of his continuing education requirement each biennium in the form of receiving live classroom instruction. The remainder may be in other forms such as videotape, audiotape, teleconference, satellite seminars, internet coursework, credits for preparation, or correspondence coursework.

8. Licensees in other states. A funeral director licensed as such by the state of New York who is maintaining his or her registration in this state while residing in another state is subject to the requirements of this section. The department may grant a non-resident licensee credit for continuing education as required by the state in which such licensee resides, provided the department deems them equivalent to New York continuing education requirements as set forth herein.

9. Late filing; fines; grace period. (a) The department shall impose a fine equal to the biennial registration fee upon a registrant who fails to file the certification of continuing education within the time prescribed under subdivision two of this section, for the first such late filing. The department shall also allow such a registrant a grace period of one hundred twenty days into the biennium to comply with this section and to file the certification. After one hundred twenty days, the department shall suspend the registration for the balance of the

biennium.

(b) A registrant who violates the filing requirements and deadlines of this section a second time shall, upon that and any subsequent violations, be subject to an additional fine of no more than five hundred dollars and suspension as the department may impose.

(c) A person who holds an inactive certificate of registration who wishes to reinstate an active registration shall complete twelve hours of continuing education prior to obtaining such active registration.

(d) A person whose registration has been suspended by the department for violating the filing requirements contained in this subdivision and who wishes to gain reinstatement of such registration shall complete twelve hours of continuing education and pay a reinstatement fee of two hundred fifty dollars to the department prior to obtaining reinstatement of such registration.

(e) With respect to paragraphs (a) and (b) of this subdivision, the department shall send the registrant by ordinary mail a notice of suspension. The suspension shall take effect no less than sixty days from the date such mailed suspension is postmarked.

10. Funeral directors shall be exempt from the mandatory continuing education requirements prescribed herein for the biennium during which they are first licensed.

11. Enforcement. (a) The department may not renew the registration of a licensed funeral director who has not complied with this section.

(b) The department may audit at random the certifications of licensees and the affidavits of providers, and may suspend or revoke the registration and/or license of a person who has knowingly made a false statement under oath.

TITLE III

PRACTICE OF FUNERAL DIRECTING; FUNERAL ESTABLISHMENTS

Section 3440. Funeral directors; duty to use prescribed tests of death.

3440-a. Statement to be furnished by certain licensed persons, funeral directors and funeral firms when funeral

arrangements are made.

- 3441. Funeral firms; operation by licensed persons.
- 3441-a. Funeral arrangements; use of flag.
- 3442. Funeral directing; reports relating to moneys paid in connection with agreements for funeral merchandise or services in advance of need.
- 3443. Funeral directing; use of names; unlicensed persons prohibited.
- 3444. Food service in funeral establishments.

§ 3440. Funeral directors; duty to use prescribed tests of death.

Before removing the body of a deceased person from the place of death or preparing it for burial by injection of fluid or otherwise, every funeral director, undertaker or embalmer shall apply such tests as are prescribed by the commissioner for determining whether life is extinct. If the body is not to be embalmed the same tests shall be made before it is prepared for burial.

§ 3440-a. Statement to be furnished by certain licensed persons, funeral directors and funeral firms when funeral arrangements are made.

Every person licensed pursuant to this article, including funeral directors and funeral firms, shall furnish at the time funeral arrangements are made for the care and disposition of the body of a deceased person, a written statement showing thereon the price of the funeral, which shall include an itemized list of the services and merchandise to be furnished for such price and a statement of the cash advances and expenditures to be advanced.

§ 3441. Funeral firms; operation by licensed persons. 1. No funeral firm shall be operated within the state unless:

(a) if the owner is an individual, he shall be a duly licensed funeral director or undertaker; if the owner is a partnership organized at any time after the seventh day of April in the year nineteen hundred forty-four and first registered with the department after that date all

partners shall be duly licensed funeral directors or undertakers; if the owner is a corporation, or is a partnership organized and registered with the department before the seventh day of April in the year nineteen hundred forty-four and having any unlicensed partners, or is the legal representative of a deceased funeral director or undertaker, the manager registered with the department shall be a duly licensed funeral director or undertaker;

(b) the owner shall biennially register with the department in accordance with the provisions of this article;

(c) the certificate of registration issued by the department to a funeral firm shall be conspicuously displayed at the funeral establishment for which the registration was issued;

(d) the license of the registered manager of a registered firm, shall be conspicuously displayed at the establishment for which the firm registration was issued;

(e) it shall be under the immediate and personal supervision, direction, management, and control of a licensed funeral director or undertaker, registered with the department, who shall not serve as the manager at more than one funeral establishment for more than one firm;

(f) all funeral directing, undertaking, and embalming shall be under the immediate and personal supervision, direction, management, and control of a duly licensed funeral director, undertaker and embalmer, respectively; and,

(g) the operation thereof and the maintenance of the establishment shall conform to the rules and regulations of the department.

2. A license or registration certificate granted or issued by the department shall not be assignable or transferable.

3. No funeral firm shall be operated or located on real property owned, leased or under the control of a cemetery corporation, a family cemetery corporation or a private cemetery corporation; or on real property dedicated for cemetery purposes or land adjacent thereto, which is owned, leased or under the control of a religious corporation, county, town, village or municipal corporation.

4. No funeral firm shall engage in the sale or cross-marketing of

goods or services with any cemetery corporation. Such prohibition shall apply to any financial relationship and co-management between a funeral firm and cemetery corporation. For the purposes of this subdivision, "cross-marketing" shall include, but not be limited to, solicitation, provider discounts (except as authorized by the regulations of the commissioner), or carrying on business or affairs between a funeral firm and cemetery corporation.

§ 3441-a. Funeral arrangements; use of flag. Upon the request of the person responsible for the payment for funeral arrangements made for the care and disposition of the body of a deceased veteran, eligible under federal law or regulations or section two hundred fifty-a of the military law for the use of a United States flag for burial purposes, every person licensed pursuant to this article, including funeral directors and funeral firms, shall furnish a United States flag for the covering of the casket at the time of the funeral free of charge. Notice of the availability of such flag shall be given at the time the itemized list of services is furnished.

§ 3442. Funeral directing; reports relating to moneys paid in connection with agreements for funeral merchandise or services in advance of need. 1. Every person licensed pursuant to this article, including funeral directors and funeral firms, receiving moneys in connection with agreements to furnish merchandise or services in connection with a funeral or burial, wherein the merchandise is not to be delivered or the personal services rendered until the occurrence of the death of the person for whose funeral or burial such merchandise or services are to be furnished, shall comply with the provisions of section four hundred fifty-three of the general business law, furnish a preneed statement to the person making such payment describing such services and merchandise offered on a form prescribed by the commissioner and shall maintain current records of the persons making such payments or receiving such merchandise or services or having been repaid moneys and shall maintain true copies of such agreements. Such records and true copies of agreements shall be made available for

inspection and shall be made available during ordinary business hours for copying upon written request by the commissioner or his or her representative in connection with any investigation pursuant to this article. Copies shall only be requested where the department has received a complaint, either oral or written, or where the department inspector has grounds to believe that serious or repeat violations of this section have occurred.

2. Only a funeral firm having a valid registration issued pursuant to paragraph (c) of subdivision two of section thirty-four hundred twenty-eight of this article or their duly authorized agent, may receive and hold moneys in trust which have been paid in connection with an agreement as described in subdivision one of this section.

3. (a) Upon the sale or other transfer of any funeral firm, or the transfer of control over such moneys, both the new owner and former owner or the estate of the former owner, or both the persons currently and formerly having control over such moneys, shall within thirty days of such sale or transfer, notify, in writing, each such person who has paid moneys of the sale or transfer, including the name and address of the new and former owner. Compliance with the requirements of this subdivision shall constitute compliance with the same notification requirements found in subdivision five of section four hundred fifty-three of the general business law. Copies of such notifications shall be available for inspection and shall be made available during ordinary business hours for copying upon written request by the commissioner or his or her representative in connection with any investigation pursuant to this article.

(b) Upon the sale or other transfer of any funeral firm having received moneys in connection with any agreement described in subdivision one of this section or upon any transfer of control over such moneys, the transferee shall be liable for compliance with all provisions of this section and section four hundred fifty-three of the general business law, including the repayment of any moneys and provision of funeral merchandise and services, if the transferor or a transferor's predecessor in interest was liable for compliance with the requirements of this section and section four hundred fifty-three of the

general business law. Such liability shall attach whether or not the successor in interest has, upon conveyance of such funeral firm, received such moneys or has knowledge of the existence of any agreements described herein. Such liability shall attach where there is proof of a valid agreement for providing funeral merchandise and services, and the funeral firm, funeral director or undertaker has not refunded the moneys received from the customer.

(c) Upon the sale or other transfer of any funeral firm having received such moneys, or upon a transfer of control of such moneys, the transferor shall disclose a complete accounting of all moneys transferred pursuant to such agreement to the transferee, including the names and addresses of all persons who deposited moneys with such funeral firm, the amount and location of such moneys, the names and addresses of persons who have received refunds and the amount of such refund.

(d) Upon the termination, cessation of operation or discontinuation of any funeral firm, or a successor in interest which has received moneys in connection with any agreement described in subdivision one of this section or is otherwise liable for compliance with the requirements of this section or section four hundred fifty-three of the general business law, such funeral firm or successor shall, within thirty days of such termination, cessation of operation or discontinuation, repay all such moneys and accrued interest as if a demand had been made therefor.

4. Records required by this section to be maintained and true copies of agreements shall be retained for four years following the provisions of funeral merchandise and services. In the event the funds are returned to the person who deposited the money or their representative, such records, including the record of return of funds shall be retained for a period of four years after the sale, transfer, termination, cessation of operation or discontinuance of the funeral firm.

§ 3443. Funeral directing; use of names; unlicensed persons prohibited. 1. The name of any living person who has not been duly licensed and is not duly registered as specified in this article shall not be

(a) shown or displayed upon or in any funeral establishment; or,
(b) used alone, in, as part of, or in connection, association, combination, or together with the name or title of any person, firm, corporation or other form of enterprise engaged in funeral directing, undertaking, or embalming or maintaining a mortuary, funeral home or other similar establishment or using in connection with such name and practice, the words funeral director, mortician, undertaker, embalmer, or any other title or words of similar meaning or import on any card, sign, stationery, or other printed, engraved or written instrument or device or in any public or private announcement or advertisement; or,
(c) used in any manner as to give or tend to give the impression that such person is licensed or practicing or entitled to practice as a funeral director, undertaker, or embalmer.

2. A person who holds a license as a funeral director or undertaker and is registered as required herein may hold himself out and advertise as a funeral director, undertaker, or mortician.

§ 3444. Food service in funeral establishments. (a) A funeral establishment may provide space, facilities, equipment or supplies for the preparation, sale, service, distribution or consumption of food or nonalcoholic beverages, limited to incidental refreshments (such as baked goods, sandwiches, snacks and platters) or those required by the religious practices of the deceased person or the deceased person's family, in the funeral establishment to or by persons in the funeral establishment for the purpose of arranging for, attending or participating in the care and preparation of a body of a deceased person for disposition, mourning, a funeral or memorial ceremony or service, or an open house or similar community function that is related to the business of funeral directing.

(b) Activities under this section may include the services of a caterer not owned by or affiliated with the funeral establishment. Activities of funeral establishment employees or catering employees shall be limited to (i) preparing such beverages and (ii) serving such incidental refreshments or nonalcoholic beverages under this section.

No activities under this section shall include the consumption of any alcoholic beverage. Notwithstanding the provisions of this section, a funeral establishment shall not operate as a food service establishment or caterer.

TITLE IV

ENFORCEMENT AND DISCIPLINE; VIOLATIONS AND PENALTIES

Section 3450. Suspension and revocation of licenses.

3451. Suspension and revocation of licenses; complaints and charges.

3453. Restoration of licenses after suspension and revocation.

3454. Restoration of licenses after conviction of a felony.

3455. Violations; prosecutions.

3456. Violations; penalties.

3457. Violations; injunctions.

§ 3450. Suspension and revocation of licenses. 1. The commissioner may revoke or suspend any license of a funeral director, undertaker or embalmer and, if such licensee shall be the owner of, or a member of a partnership owning, a funeral firm or the licensed and registered manager of a funeral firm owned by a corporation, any certificate of registration of such firm, or may reprimand or otherwise discipline such licensee or funeral firm in accordance with the provisions of this article upon proof that such licensee or, in the case of such corporation, that the corporation or one or more of its officers or directors or one or more of its stockholders or other persons, firms or corporations having a ten per centum or greater proprietary, beneficial, equitable or credit interest therein:

(a) has violated any of the provisions of this article, the sanitary code, the rules and regulations of the commissioner or of any statute, code, rule or regulation relating to the practice of funeral directing, embalming, or vital statistics;

(b) has been convicted of a crime;

(c) has practiced fraud, deceit or misrepresentation in securing or procuring a license or admission to practice funeral directing,

undertaking, or embalming;

(d) is incompetent to engage in the business or practice of funeral directing, undertaking, or embalming except that this provision shall not apply to an officer, director or stockholder of, or other person interested in, a corporation owning a funeral firm unless he shall be the licensed and registered manager thereof;

(e) has practiced fraud, deceit, or misrepresentation in his business or practice or in the business of such funeral firm;

(f) has committed acts of misconduct in the conduct of the business or practice of funeral directing, undertaking, or embalming or in the business of such funeral firm;

(g) is an habitual drunkard;

(h) is addicted to the use of morphine, opium, cocaine or other drugs having a similar effect;

(i) has practiced or conducted the business of such funeral firm without biennial registration of his license or of such firm;

(j) has employed, hired, procured or induced or otherwise aided or abetted any person not licensed or registered to practice or hold himself out as licensed, practicing, or entitled to practice as an undertaker, or embalmer, or funeral director;

(k) has wrongfully transferred or surrendered possession, either temporarily or permanently, of his license or certificate of registration thereof or of the certificate of registration of such funeral firm to any other person, partnership or corporation;

(l) has paid, given, has caused to be paid or given or offered to pay or to give to any person a commission or other valuable consideration for the solicitation or procurement, either directly or indirectly, of funeral patronage, or has accepted any consideration (including without limitation a commission, rebate, or discount or direct or indirect price reduction on merchandise from the current value thereof) from any financial institution or trust company, or agent thereof, with whom the funeral director deposits funds paid for funeral services in advance of need pursuant to subdivision one of section four hundred fifty-three of the general business law except that the funeral director may accept, from the financial institution, trust company or agent thereof, up to twenty-five hundredths of one percent of the fee authorized under paragraph (b) of subdivision three of section four hundred fifty-three

of the general business law for administrative services provided by the funeral director, or has accepted any consideration (including without limitation a commission or gift) from any insurer or agent thereof, to sell, offer or promote the sale of any policy of insurance payable, expressly or as marketed, at the death of the insured for funeral or burial expenses;

(m) has been guilty of fraudulent, misleading or deceptive advertising;

(n) has practiced funeral directing, undertaking or embalming, or has conducted business as a funeral firm, under a false name;

(o) has impersonated another licensee or another funeral firm of a like or different name; or

(p) has failed to comply with requirements set forth in section four hundred fifty-three of the general business law, relating to moneys paid in connection with agreements for funeral merchandise in advance of need to be kept on deposit pending use or repayment except, that revocation and suspension shall apply only in the case where a funeral director or funeral firm has committed repeated violations of these provisions or has committed a violation of the provisions of section four hundred fifty-three of the general business law relating to failure to deposit or hold moneys on deposit; failure to return such moneys and interest thereon upon demand or upon the termination, cessation of operation or discontinuance of any funeral firm, or a successor in interest; or failure to comply with the requirements of paragraph (b) of subdivision five of section four hundred fifty-three of the general business law regarding compliance by transferors who receive such moneys.

2. The commissioner shall also have power, and after due notice and an opportunity to be heard, to revoke or suspend the endorsement of a funeral director, undertaker or embalmer license issued to any person pursuant to the provisions of this article or any previous law upon evidence that the duly constituted authorities of any state or political subdivision of the United States have lawfully revoked or suspended the funeral director, undertaker or embalmer license issued to such person by such state or political subdivision.

3. The action of the commissioner in revoking or suspending such

license or certificate of registration of such funeral firm shall be reviewable by the supreme court of the state of New York pursuant to the provisions of article seventy-eight of the civil practice law and rules.

4. (a) A person convicted of a felony shall forfeit his license to practice as a funeral director, undertaker, or embalmer, and upon presentation to the department of a certified copy of a court record showing that he has been convicted of a felony, that fact shall be noted on the record of license, and the license shall be revoked, and the registration shall be cancelled.

(b) If such conviction be subsequently reversed on appeal and the accused acquitted or discharged, his license shall become again operative from the date of such acquittal or discharge.

(c) The conviction of a felony aforementioned shall include the conviction of a felony by any court in this state or by any court of the United States or by any court of any other state of the United States; provided, however, that if a crime of which the licensee is convicted by any court of the United States or by any court of any other state is a felony in the jurisdiction in which the conviction is had but is not a felony in the state of New York, then the conviction shall not be deemed a conviction of a felony for the purposes of this article. In the event that a crime of which the licensee is convicted by any court of the United States or by any court of any other state is not a felony in the jurisdiction in which the conviction is had but is a felony in the state of New York, then the conviction shall be deemed a conviction of a felony for the purposes of this article.

§ 3451. Suspension and revocation of licenses; complaints and charges.

1. (a) Any person, public officer, or association, or the department may for due cause, prefer charges pursuant to the provisions of this chapter against any licensee.

(b) Such charges shall be in writing and verified under oath and shall be submitted to the department.

2. (a) The commissioner or any person or persons appointed by him for the purpose, may hold a preliminary hearing to determine whether a trial

on the formal charges is necessary.

(b) The commissioner may dismiss the charges and take no action thereon, by formal hearing or otherwise, in his discretion, in the event that he or the person or persons thus appointed by him do not deem a formal hearing necessary, in which event the charges and the order dismissing the charges shall be filed with the department.

3. (a) If the commissioner or the person or persons thus appointed by him decide that the charges shall be heard, the commissioner shall designate a hearing officer to determine the charges and set a time and place for a hearing.

(b) A copy of the charges, together with notice of the time and place of the hearing, shall be served on the accused in accordance with section twelve-a of this chapter.

4. (a) Upon the conclusion of the hearing, the commissioner may revoke the license of the accused, or suspend such license for a fixed period, or reprimand, or take such other disciplinary action in accordance with this article, or dismiss the charges.

(b) An order or suspension made by the commissioner may contain such provisions as to reinstatement of the license as the commissioner shall direct.

(c) The commissioner, in his discretion, may direct a rehearing or take additional evidence, and may rescind or affirm the prior determination after such rehearing, but nothing in this subdivision shall preclude appropriate relief under article seventy-eight of the civil practice act.

§ 3453. Restoration of licenses after suspension and revocation. 1. The commissioner may, in his discretion, reissue a license to any person whose license has been revoked.

2. Application for the reissuance of a license shall not be made prior to one year after revocation and shall be made in such manner as the commissioner may direct.

§ 3454. Restoration of licenses after conviction of a felony. If a person convicted of a felony or crime deemed to be a felony is subsequently pardoned by the governor of the state where such conviction was had or by the president of the United States, or shall receive a certificate of relief from disabilities or a certificate of good conduct pursuant to article twenty-three of the correction law to remove the disability under this section because of such conviction, the commissioner may, in his discretion, on application of such person, and on the submission to him of satisfactory evidence, restore to such person the right to practice in this state.

§ 3455. Violations; prosecutions. 1. Any person who shall:

(a) obtain or attempt to obtain or aid in obtaining any license or certificate under this article by any false or fraudulent statement or representation; or,

(b) practice as a funeral director, undertaker or embalmer without having been issued a license or without having registered as required by this article; or,

(c) being a funeral director, undertaker, or embalmer, aid and abet an unlicensed person to practice funeral directing, undertaking, and embalming; or,

(d) hold himself out as licensed or able to practice or as practicing or entitled to practice without conformity to the requirements of this article; or,

(e) otherwise violate or neglect to comply with any of the provisions of this article; or,

(f) being a funeral director, undertaker or embalmer, or registered resident, knowingly give, sell, permit to be sold, offer for sale or display for sale, other than for purposes within the general scope of their activities as a licensed funeral director, undertaker or embalmer, or registered resident, embalming fluid to another person with actual knowledge that such other person is not a licensed funeral director, undertaker or embalmer, or registered resident, or entity authorized to perform embalming activities under section thirty-four hundred twenty of this article or activities described in article forty-two of this

chapter; or

(g) practice as a funeral director, undertaker or embalmer, while his license is revoked or suspended, shall be guilty of a misdemeanor, and shall, on conviction, for each and every offense be punished by a fine of not less than one hundred dollars nor more than five hundred dollars, or by imprisonment for a term of not less than thirty days and not more than one year, or by both such fine and imprisonment, and for a second offense shall be punishable by both such fine and imprisonment.

2. All courts of special sessions within their respective territorial jurisdictions are hereby empowered to hear, try and determine such crimes without indictment and to impose in full the punishments of fines and imprisonments herein prescribed.

3. The attorney general of the state shall have the power to prosecute in any county of the state any violation of this article; such prosecution may be instituted by him in his discretion or after complaint made to him by any person, provided, however, that nothing in this section shall be interpreted to prevent or impede the prosecution of such proceedings by the district attorney of any county in which the offense is committed when such proceedings have been instituted by him.

4. (a) In any prosecution or hearing hereunder it shall be necessary to prove only a single act prohibited by law or a single holding out or attempt, without having to prove a general course of conduct, in order to constitute a violation.

(b) The display, publication or dissemination by any person of an advertisement, card, sign or any other representation bearing a name, designation or description as a practitioner of funeral directing, undertaking, or embalming, in any manner or by implication, shall be presumptive evidence of a holding out of such practice by such person.

5. All violations of this article when reported to the department and duly substantiated by affidavits, or other satisfactory evidence, shall be investigated and, if the report is found to be substantiated, the department shall report such violations to the attorney general and request prompt prosecution.

§ 3456. Violations; penalties. 1. Any person who shall engage in the business or practice of funeral directing, undertaking or embalming in violation of any provisions of this article, shall be liable to a maximum civil penalty of one thousand dollars, suspension or revocation of license, or other disciplinary action, as specified by law for each such violation and may also be found guilty of a misdemeanor.

2. Each day during which or any part of which any such prohibited business or practice is continued shall be deemed a separate violation.

3. One or more penalties for one or more violations by the same person within any period of time may be sued for and recovered by the attorney general in the name of the people of the state.

§ 3457. Violations; injunctions. 1. (a) The attorney general may maintain an action upon his own information or upon the complaint of any person against any person, partnership, corporation or association, and any employee, agent, director or officer thereof, who shall violate any of the provisions of this article.

(b) In such action the final judgment in favor of the plaintiff must perpetually restrain the defendant or defendants from the commission or continuance of the acts complained of.

(c) A temporary injunction to restrain the commission or continuance of the acts complained about may be granted upon proof, by affidavit, that the defendant has or defendants have violated any of the provisions of this article. The provisions of statute or rule relating generally to injunctions as provisional remedies in actions shall apply to such temporary injunction and the proceedings thereupon.

2. The plaintiff in such action shall be entitled to an examination before trial of the defendant or defendants and of witnesses as to testimony that is material and necessary in such action.

3. The action aforesaid shall be in addition to any penal proceedings.

ARTICLE 35

PRACTICE OF RADIOLOGIC TECHNOLOGY

- Title I. General provisions and public policy (Secs. 3500-3501).
II. Licensing and registration (Secs. 3502-3508).
III. Violations; penalties (Secs. 3510-3514).
IV. Construction (Secs. 3515-3517).

TITLE I

GENERAL PROVISIONS AND PUBLIC POLICY

- Section 3500. Declaration of policy and statement of purpose.
3501. Definitions.

§ 3500. Declaration of policy and statement of purpose. It is declared to be the policy of the state of New York that the health and safety of the people of the state must be protected against the harmful effects of excessive and improper exposure to ionizing radiation and from inadequately performed diagnostic tests and radiation therapy treatments. Such protection can best be accomplished by requiring adequate training and experience of persons under the supervision of licensed practitioners as defined in this title. It is the purpose of this article to establish standards of education, training and experience and to require the examination and licensure of radiographers, radiation therapists and nuclear medicine technologists.

§ 3501. Definitions. When used in this article, the following words and phrases shall have the following definitions:

1. "Radiologic technology" means the practice of radiography, radiation therapy and nuclear medicine technology.
2. "Radiologic technologist" means a person who is licensed under this article to practice radiography or radiation therapy or nuclear

medicine.

3. "Radiography" means the use of x-rays or x-ray producing equipment on human beings for diagnostic purposes under the supervision of a licensed practitioner. The practice includes, but is not limited to: measuring and positioning patients; selecting and setting up exposure factors on x-ray equipment, and the making of the x-ray exposure; the performance of quality control tests; under the direct supervision of a licensed physician, the intravascular administration of contrast media when such administration is an integral part of the x-ray or imaging procedure; and, under the direct supervision of a licensed physician, certified nurse practitioner, or licensed physician assistant, the intravenous administration of contrast media when such administration is an integral part of the x-ray or imaging procedure.

4. "Radiographer" means a person, other than a licensed practitioner, who is licensed under this article to practice radiography.

5. "Radiation therapy" means the use of external beam and remote afterloading brachytherapy equipment for the application of ionizing radiation to human beings for therapeutic purposes under the supervision of a radiation oncologist. The practice includes but is not limited to: setting up treatment position; selecting required filter and treatment distance; positioning the beam directional shells and molds; using x-ray equipment for tumor localization; delivering the radiation treatment as prescribed by the physician; certifying the record of the technical details of the treatments; assisting the professional medical physicist in calibration procedures; assisting in treatment planning procedures; and the performance of quality control tests.

6. "Radiation therapist" means a person, other than a licensed physician, who is licensed under this article to practice radiation therapy.

7. "Nuclear medicine technology" means the use of radiopharmaceuticals administered to human beings for diagnostic or therapeutic purposes under the supervision of a physician authorized by a radioactive

materials license. The practice includes but is not limited to: elution of a radiopharmaceutical generator; dosage preparation; assay of radiopharmaceutical dosages administered to patients; use of nuclear medicine equipment on patients; performance of quality control tests; administration of radiopharmaceuticals to patients for diagnostic purposes; and administration of radioactive materials to patients for therapeutic purposes under the personal supervision of a physician authorized by a radiopharmaceuticals license for such use.

8. "Nuclear medicine technologist" means a person who is licensed under this article to practice nuclear medicine technology.

9. "Radiologist" means a physician duly licensed to practice medicine in the state of New York and who is certified by the American Board of Radiology or by the American Osteopathic Board of Radiology in diagnostic radiology or radiation oncology.

10. "Radiation oncologist" means a physician duly licensed to practice medicine in the state of New York and who is certified by the American Board of Radiology or by the American Osteopathic Board of Radiology in radiation oncology.

11. "Licensed practitioner" means a person licensed or otherwise authorized under the education law to practice medicine, dentistry, podiatry, or chiropractic.

12. "Professional medical physicist" means a person licensed or otherwise authorized to practice medical physics in accordance with article one hundred sixty-six of the education law.

14. "License" means a license granted and issued by the department under this article to practice radiography, radiation therapy technology or nuclear medicine technology.

15. "X-ray or imaging procedure" means and includes conventional diagnostic x-ray or radiology, computer tomography, angiography, magnetic resonance imaging and ultrasound.

16. "Intravenous contrast administration certificate" means a certificate granted and issued by the department under this article to administer and inject contrast media.

17. "Supervision" means the oversight of a licensed radiologic technologist by a licensed practitioner acting within the limits specified in the law under which the practitioner is licensed.

18. "Direct supervision" means a physician must be present in the section of the facility where the procedure is being performed and is not concurrently encumbered by responsibilities that would preclude the physician from responding to a request for assistance within a timeframe that poses no risk to the patient. The physician shall be immediately available to furnish assistance and direction throughout the performance of the procedure, and is professionally responsible for the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

19. "Personal supervision" means the physician must be in attendance in the room during the performance of the procedure.

TITLE II

LICENSING AND REGISTRATION

Section 3502. License required.

3504. Rules and regulations.

3505. Requirements for a professional license.

3506. Temporary permits.

3507. Registration.

3508. Registration of schools.

§ 3502. License required. 1. The department shall issue separate licenses in the areas of radiography, radiation therapy and nuclear medicine technology to individuals who qualify under section thirty-five hundred five of this title.

2. Except where otherwise authorized by law:

(a) only licensed practitioners and persons licensed under this article are permitted to apply ionizing radiation to human beings, and only within the limits of their specific license;

(b) only licensed physicians who are authorized by a radioactive materials license or persons licensed under this article are permitted to use radiopharmaceuticals on human beings, and only within the limits of their specific license;

(c) only persons licensed under this article shall practice radiography, radiation therapy or nuclear medicine technology or use the title "radiographer," "radiologic technologist," "radiation therapist" or "nuclear medicine technologist" or use the abbreviations LRT, RTT, LRTT, NMT, or LNMT with his or her name; and

(d) notwithstanding paragraph (c) of this subdivision, quality control tests and radiation therapy treatment planning may also be performed by individuals not licensed by this article.

3. On or after January first, two thousand nine no person shall practice nuclear medicine technology or hold himself or herself out as a nuclear medicine technologist unless the individual is the holder of a license pursuant to this article and in accordance with the commissioner's rules and regulations.

4. No radiologic technologist shall administer or inject intravenous contrast media unless (a) the individual is certified by the department to perform such function in accordance with the commissioner's rules and regulations (b) such administration or injection has been approved by a physician, physician's assistant, nurse practitioner or registered professional nurse within twenty-four hours prior to the administration or injection (c) a physician, physician's assistant, nurse practitioner or registered professional nurse performs an evaluation of the patient on the day of the procedure. Administration or injection of contrast media means and is limited to the placement or insertion of a needle or a catheter, not exceeding three inches in length and not above the level of the axilla into a person's upper extremity and the administration or injection of the intravenous contrast media, manually or by mechanical

injector, but does not mean the determination of the type or volume of media to be administered or injected.

5. The department shall issue an intravenous contrast administration certificate, as defined in this article, to an individual who is approved by the department. Such individual must:

(a) be a duly licensed and registered radiologic technologist in good standing under this article;

(b) demonstrate the satisfactory completion of education and training concerning the insertion of a needle and a catheter;

(c) demonstrate the satisfactory completion of training in recognition of adverse reactions and cardiopulmonary resuscitation;

(d) pay a biennial certification fee of twenty dollars; and

(e) meet such other criteria as may be established by the commissioner in regulation.

* 6. (a) (i) Notwithstanding the provisions of this section or any other provision of law, rule or regulation to the contrary, licensed practitioners, persons licensed under this article and unlicensed personnel employed at a local correctional facility may, in a manner permitted by the regulations promulgated pursuant to this subdivision, utilize body imaging scanning equipment that applies ionizing radiation to humans for purposes of screening incarcerated individuals committed to such facility, in connection with the implementation of such facility's security program.

(ii) Notwithstanding the provisions of this section or any other provision of law, rule or regulation to the contrary, licensed practitioners, persons licensed under this article and unlicensed personnel employed at a state correctional facility may, in a manner permitted by the regulations promulgated pursuant to this subdivision, utilize body imaging scanning equipment that applies ionizing radiation to humans for purposes of screening individuals detained in, committed to, visiting, or employed in such facility, in connection with the implementation of such facility's security program.

(iii) The utilization of such body imaging scanning equipment shall be in accordance with regulations promulgated by the department, or for local correctional facilities in cities having a population of two million or more, such utilization shall be in accordance with

regulations promulgated by the New York city department of health and mental hygiene. The state commission of correction, in consultation with the department of corrections and community supervision, shall promulgate regulations establishing when body imaging scanning equipment will be used to screen visitors and incarcerated individuals in state correctional facilities. Such regulations shall include provisions establishing that alternative methods of screening may be used to accommodate individuals who decline or are unable to be screened by body imaging scanning equipment for medical reasons and that alternative methods of screening may be used to accommodate individuals who decline to be screened for other reasons, unless security considerations warrant otherwise. Such regulations shall also ensure that no person shall be subjected to any form of harassment, intimidation, or disciplinary action for choosing to be searched by an alternative method of screening in lieu of body imaging scanning.

The department of corrections and community supervision shall promulgate regulations establishing when body imaging scanning equipment will be used to screen employees of the department of corrections and community supervision, provided, however that such regulations shall be consistent with the policies and procedures of the department of corrections and community supervision governing the search of employees. Such regulations shall include provisions establishing that alternative methods of screening may be used to accommodate individuals who decline or are unable to be screened by body imaging scanning equipment for medical or other reasons. Such regulations shall also ensure that no person shall be subjected to any form of harassment, intimidation, or disciplinary action for choosing to be searched by an alternative method of screening in lieu of body imaging scanning. An employee's request to be searched by an alternative method of screening in lieu of body imaging scanning shall not, in itself, be grounds for disciplinary action against such employee.

(b) Prior to establishing, maintaining or operating in a state or local correctional facility, any body imaging scanning equipment, the chief administrative officer of the facility shall ensure that such facility is in compliance with the regulations promulgated pursuant to this subdivision and otherwise applicable requirements for the

installation, registration, maintenance, operation and inspection of body imaging scanning equipment.

(c) The regulations promulgated pursuant to subparagraph (ii) of paragraph (a) of this subdivision shall include, but not be limited to:

(i) A requirement that prior to operating body imaging scanning equipment, unlicensed personnel employed at state or local correctional facilities shall have successfully completed a training course approved by the department, or for local correctional facilities in cities of two million or more, approved by the New York city department of health and mental hygiene, and that such personnel receive additional training on an annual basis;

(ii) Limitations on exposure which shall be no more than fifty percent of the annual exposure limits for non-radiation workers as specified by applicable regulations, except that individuals under the age of eighteen shall not be subject to more than five percent of such annual exposure limits, and pregnant women shall not be subject to such scanning at any time. Procedures for identifying pregnant women shall be set forth in the regulations;

(iii) Registration with the department of each body imaging scanning machine purchased or installed at a state or local correctional facility;

(iv) Inspection and regular reviews of the use of body imaging scanning equipment by the department or the New York city department of health and mental hygiene, as applicable; and

(v) A requirement that records be kept regarding each use of body imaging scanning equipment by the state or local correctional facility.

(d) For the purpose of this subdivision, "body imaging scanning equipment" or "equipment" means equipment that utilizes a low dose of ionizing radiation to produce an anatomical image capable of detecting objects placed on, attached to or secreted within a person's body.

(e) For the purposes of this subdivision:

(i) "Local correctional facility" shall have the same meaning as found in subdivision sixteen of section two of the correction law.

(ii) "State correctional facility" shall mean a "correctional facility" as defined in subdivision four of section two of the correction law.

(f) Any local government agency that utilizes body imaging scanning

equipment in a local correctional facility under its jurisdiction shall submit an annual report to the department, the speaker of the assembly, and the temporary president of the senate. If body imaging scanning equipment is utilized in one or more state correctional facilities, the department of corrections and community supervision shall submit an annual report to the department, the speaker of the assembly, and the temporary president of the senate. Such report by either the local government agency or the department of corrections and community supervision shall be submitted within eighteen months after the initial date of registration of such equipment with the department, and annually thereafter, and shall contain the following information as to each such facility:

(i) For local correctional facilities, the number of times the equipment was used on incarcerated individuals upon intake, after visits, and upon the suspicion of contraband, as well as any other event that triggers the use of such equipment, and the average, median, and highest number of times the equipment was used on any incarcerated individual, with corresponding exposure levels; and

(ii) For state correctional facilities, the number of times the equipment was used on individuals detained in, committed to, working in, or visiting the facility upon intake, before work shift, after work shift, before visits, after visits, and upon the suspicion of contraband, as well as any other event that triggers the use of such equipment, and the average, median, and highest number of times the equipment was used on any individual detained in, committed to, working in, or visiting the facility, with corresponding exposure levels.

(iii) the number of times the use of the equipment detected the presence of drug contraband, weapon contraband, and any other illegal or impermissible object or substance;

(iv) incidents or any injuries or illness resulting from the use of such equipment or reported by persons scanned by such equipment; and

(v) any other information the department may reasonably require.

* NB Effective until October 3, 2026

* 6. (a) (i) Notwithstanding the provisions of this section or any other provision of law, rule or regulation to the contrary, licensed practitioners, persons licensed under this article and unlicensed personnel employed at a local correctional facility, or secure or

specialized secure detention facility may, in a manner permitted by the regulations promulgated pursuant to this subdivision, utilize body imaging scanning equipment that applies ionizing radiation to humans for purposes of screening incarcerated individuals committed to such local correctional facility, or individuals detained in, committed to, visiting or employed in a secure or specialized secure detention facility, in connection with the implementation of such facility's security program.

(ii) Notwithstanding the provisions of this section or any other provision of law, rule or regulation to the contrary, licensed practitioners, persons licensed under this article and unlicensed personnel employed at a state correctional facility or facility for youth placed with or committed to the office of children and family services may, in a manner permitted by the regulations promulgated pursuant to this subdivision, utilize body imaging scanning equipment that applies ionizing radiation to humans for purposes of screening individuals detained in, committed to, visiting, or employed in such facility, in connection with the implementation of such facility's security program.

(iii) The utilization of such body imaging scanning equipment shall be in accordance with regulations promulgated by the department, or for local correctional facilities in cities having a population of two million or more, such utilization shall be in accordance with regulations promulgated by the New York city department of health and mental hygiene. The state commission of correction, in consultation with the department of corrections and community supervision and the office of children and family services, shall promulgate regulations establishing when body imaging scanning equipment will be used to screen visitors and individuals detained in or committed to state correctional facilities, secure or specialized secure detention facilities, or facilities for youth placed with or committed to the office of children and family services. Such regulations shall include provisions establishing that alternative methods of screening may be used to accommodate individuals who decline or are unable to be screened by body imaging scanning equipment for medical reasons and that alternative methods of screening may be used to accommodate individuals who decline to be screened for other reasons, unless security considerations warrant

otherwise. Such regulations shall also ensure that no person shall be subjected to any form of harassment, intimidation, or disciplinary action for choosing to be searched by an alternative method of screening in lieu of body imaging scanning.

The department of corrections and community supervision and the office of children and family services shall promulgate regulations establishing when body imaging scanning equipment will be used to screen employees of the department of corrections and community supervision and the office of children and family services, provided, however that such regulations shall be consistent with the policies and procedures of the department of corrections and community supervision and the office of children and family services governing the search of employees. Such regulations shall include provisions establishing that alternative methods of screening may be used to accommodate individuals who decline or are unable to be screened by body imaging scanning equipment for medical or other reasons. Such regulations shall also ensure that no person shall be subjected to any form of harassment, intimidation, or disciplinary action for choosing to be searched by an alternative method of screening in lieu of body imaging scanning. An employee's request to be searched by an alternative method of screening in lieu of body imaging scanning shall not, in itself, be grounds for disciplinary action against such employee.

(b) Prior to establishing, maintaining or operating any body imaging scanning equipment in a state or local correctional facility, secure or specialized secure detention facility, or facility for youth placed with or committed to the office of children and family services, the chief administrative officer of the facility shall ensure that such facility is in compliance with the regulations promulgated pursuant to this subdivision and otherwise applicable requirements for the installation, registration, maintenance, operation and inspection of body imaging scanning equipment.

(c) The regulations promulgated pursuant to subparagraph (ii) of paragraph (a) of this subdivision shall include, but not be limited to:

(i) A requirement that prior to operating body imaging scanning equipment, unlicensed personnel employed at state or local correctional facilities, secure or specialized secure detention facilities, or

facilities for youth placed with or committed to the office of children and family services shall have successfully completed a training course approved by the department, or for local correctional facilities in cities of two million or more, approved by the New York city department of health and mental hygiene, and that such personnel receive additional training on an annual basis;

(ii) Limitations on exposure which shall be no more than fifty percent of the annual exposure limits for non-radiation workers as specified by applicable regulations, except that individuals under the age of eighteen shall not be subject to more than five percent of such annual exposure limits, and pregnant women shall not be subject to such scanning at any time. Procedures for identifying pregnant women shall be set forth in the regulations;

(iii) Registration with the department of each body imaging scanning machine purchased or installed at a state or local correctional facility, secure or specialized secure detention facility, or facility for youth placed with or committed to the office of children and family services;

(iv) Inspection and regular reviews of the use of body imaging scanning equipment by the department or the New York city department of health and mental hygiene, as applicable; and

(v) A requirement that records be kept regarding each use of body imaging scanning equipment by the state or local correctional facility, secure or specialized secure detention facility, or facility for youth placed with or committed to the office of children and family services.

(d) For the purpose of this subdivision, "body imaging scanning equipment" or "equipment" means equipment that utilizes a low dose of ionizing radiation to produce an anatomical image capable of detecting objects placed on, attached to or secreted within a person's body.

(e) For the purposes of this subdivision:

(i) "Local correctional facility" shall have the same meaning as found in subdivision sixteen of section two of the correction law.

(ii) "State correctional facility" shall mean a "correctional facility" as defined in subdivision four of section two of the correction law.

(iii) "Secure detention facility" shall mean a secure detention facility certified by the office of children and family services

pursuant to section five hundred three of the executive law.

(iv) "Specialized secure detention facility" shall mean a facility for adolescent offenders certified by the office of children and family services in consultation with the state commission of correction pursuant to subdivision nine of section five hundred three of the executive law.

(v) "Facility for youth placed with or committed to the office of children and family services" shall mean a facility operated pursuant to section five hundred four of the executive law.

(f) Any local government agency that utilizes body imaging scanning equipment in a local correctional, or secure or specialized secure detention facility under its jurisdiction shall submit an annual report to the department, the speaker of the assembly, and the temporary president of the senate. If body imaging scanning equipment is utilized in one or more state correctional facilities or facilities for youth placed with or committed to the office of children and family services, the department of corrections and community supervision or the office of children and family services, as applicable, shall submit an annual report to the department, the speaker of the assembly, and the temporary president of the senate. Such report by the local government agency, the department of corrections and community supervision or the office of children and family services shall be submitted within eighteen months after the initial date of registration of such equipment with the department, and annually thereafter, and shall contain the following information as to each such facility:

(i) for local correctional facilities, the number of times the equipment was used on incarcerated individuals, or for secure or specialized secure detention facilities, the number of times the equipment was used on individuals placed with, committed to, visiting or employed in such facility, upon intake, after visits, and upon the suspicion of contraband, as well as any other event that triggers the use of such equipment, and the average, median, and highest number of times the equipment was used on any such individual, with corresponding exposure levels;

(ii) for state correctional facilities or facilities for youth placed with or committed to the office of children and family services, the number of times the equipment was used on individuals detained in,

committed to, working in, or visiting the facility upon intake, before work shift, after work shift, before visits, after visits, and upon the suspicion of contraband, as well as any other event that triggers the use of such equipment, and the average, median, and highest number of times the equipment was used on any individual detained in, committed to, working in, or visiting the facility, with corresponding exposure levels;

(iii) the number of times the use of the equipment detected the presence of drug contraband, weapon contraband, and any other illegal or impermissible object or substance;

(iv) incidents or any injuries or illness resulting from the use of such equipment or reported by persons scanned by such equipment; and

(v) any other information the department may reasonably require.

* NB Effective October 3, 2026

* NB Repealed January 30, 2029

§ 3504. Rules and regulations. The commissioner shall have power to make such rules and regulations, not inconsistent with law, as may be necessary to carry out the provisions of this article, including but not limited to, the availability of emergency equipment appropriate to provide treatment in the event of an unanticipated reaction to the administration of contrast media.

§ 3505. Requirements for a professional license. 1. To qualify for a license under this article, an applicant shall fulfill the following requirements:

(a) Application: file an application with the department;

(b) Education: have received an education in accordance with regulations set forth by the commissioner;

(c) Examination: pass an examination in accordance with the commissioner's regulations;

(d) Age: be at least eighteen years of age;

(e) Character: be of good moral character; and

(f) Fees: pay a license fee of one hundred twenty dollars to the department.

2. Notwithstanding paragraph (a) of subdivision one of this section, no person shall be admitted to the examination who has failed to pass the examination on three attempts unless that individual provides documented evidence of the completion of a course of study as defined by the commissioner in rules and regulations.

3. No person shall be licensed who has been convicted of any crime consistent with the provisions of article twenty-three-A of the correction law.

§ 3506. Temporary permits. The department may in its discretion and upon written application issue a temporary permit to practice radiologic technology in this state to a person who qualifies under section thirty-five hundred five of this title for admission to an examination for licensure. A temporary permit shall not be issued to a person who has had a license or registration suspended, revoked or annulled, or who has been otherwise disciplined pursuant to the provisions of section thirty-five hundred ten of this article. A temporary permit shall expire one hundred eighty days from the date of issuance.

§ 3507. Registration. 1. A license shall be valid during the life of the holder unless revoked, annulled or suspended by the commissioner. A practicing licensee must register with the department.

2. The commissioner shall promulgate such rules and regulations as are necessary to effectuate the provisions of this section including, but not limited to, establishing staggered registration periods and the beginning dates thereof; assigning licensees to specific registration periods through appropriate classification or grouping; setting deadline dates for making application for registration; prescribing the form and content of the certificate of registration; and establishing other reasonable requirements, including appropriate proration of registration fees.

3. A person licensed under this article must register with the department prior to commencing practice. The department shall register each licensee who submits an application on a form prescribed by the commissioner and who pays a registration fee of twenty dollars per year.

4. Any licensee authorized to practice under this article, undertaking practice for the first time or resuming practice after a voluntary lapse of registration, may commence practice upon mailing to the department the proper application for registration together with the required fee, provided, however, that such practice without actual possession of the certificate of registration is limited to thirty days. Any such licensee whose application for registration is submitted subsequent to the beginning of the registration period applicable to such licensee shall only be required to pay one-half of the fee if the registration period is less than one-half the whole thereof.

5. Upon receipt of satisfactory evidence that a certificate of registration has been lost, mutilated or destroyed, the department may issue a duplicate certificate upon such terms and conditions as the commissioner shall prescribe.

6. The department may waive registration fees for a licensee who registers after an elapsed period under the following circumstances:

- (a) the registration period has expired; and
- (b) the licensee provides the department with a notarized statement attesting to the fact that the licensee has not practiced within this state during the elapsed registration period.

7. The department may require that licensees provide proof of completion of continuing education credits for registration of their license or intravenous contrast administration certificate in accordance with the commissioner's regulations.

§ 3508. Registration of schools. No person, institution or agency shall offer a course of study in radiologic technology unless such course of study is registered by the department or by the department of

education and meets such standards of quality, character and competence of sponsors and officials, financial resources, public need, and other pertinent matters as may be prescribed by the commissioner or by the commissioner of education in appropriate rules and regulations. A registered school of radiologic technology may be operated by a medical or educational institution, and for the purpose of providing the requisite clinical experience shall be affiliated with one or more general hospitals approved by the department or by the department of education.

TITLE III

VIOLATIONS; PENALTIES

Section 3510. Suspension or revocation.

3511. Proceedings for suspension or revocation.

3512. Penalties.

3513. Disposition of fees, fines, penalties and other moneys.

3514. Injunctive relief.

§ 3510. Suspension or revocation. 1. The license, registration or intravenous contrast administration certificate of a radiologic technologist may be suspended for a fixed period, revoked or annulled, or such licensee censured, reprimanded, subject to a civil penalty not to exceed two thousand dollars for every such violation, or otherwise disciplined, in accordance with the provisions and procedures defined in this article, provided that no civil penalty shall be assessed for any crime or misconduct that occurred outside the jurisdiction of New York state upon decision after due hearing that the individual is guilty of the following misconduct:

(a) any fraud or deceit in the practice or has been guilty of any fraud or deceit in procuring a license, registration or certificate;

(b) conviction in a court of competent jurisdiction, either within or without this state, of a crime involving moral character;

(c) being a habitual abuser of alcohol or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens or other drugs having similar effects. Exceptions may be made for a

licensee who is maintained on an approved therapeutic regimen which does not impair the ability to practice;

(d) aiding and abetting in the practice of radiologic technology a person who is not a registered radiologic technologist or who is practicing a form of radiologic technology which is beyond the scope of the individual's license;

(e) engaging in any practice beyond the scope of the practice of radiologic technology or beyond the scope of the individual's license as defined in this article;

(f) falsely impersonating a duly registered radiologic technologist or former duly registered radiologic technologist, or is practicing radiologic technology under an assumed name;

(g) unethical conduct as defined by rules promulgated by the commissioner;

(h) failure to obtain a certificate of registration as required by section thirty-five hundred seven of this article;

(i) applying radiation to a human being when not under the necessary supervision of a duly licensed practitioner as defined in this article, or to any person or part of the human body other than those specified in the law under which such practitioner is licensed;

(j) expressing to a member of the public an interpretation of medical test results;

(k) using the prefix "Dr.", the word "doctor" or any suffix or affix to indicate or imply that the licensee is a duly licensed practitioner as defined in this article when not so licensed;

(l) incompetence or negligence;

(m) being convicted of a crime which has a direct relationship to the employment or licensure at issue or poses an unreasonable risk to public safety pursuant to article twenty-three-a of the correction law and is a conviction under (i) New York state law; (ii) federal law; or (iii) the law of another jurisdiction which, if committed within this state, would have constituted professional misconduct under New York state law;

(n) having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based, if committed in New York state, would constitute professional misconduct under the laws of New York state;

(o) having been found guilty in an adjudicatory proceeding of violating a state or federal statute or regulation, pursuant to a final decision or determination, and when no appeal is pending, or after resolution of the proceeding by stipulation or agreement, and when the violation would constitute professional misconduct under the laws of New York state; or

(p) having his or her license to practice as a radiologic technologist revoked, suspended or having other disciplinary action taken, or having his or her application for a license refused, revoked or suspended or having voluntarily or otherwise surrendered his or her license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or refusal, revocation or suspension of an application for a license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state. A radiologic technologist licensed in New York state who is also licensed or seeking licensure in another state must immediately report to the department any revocation, suspension or other disciplinary action involving the out-of-state license or refusal, revocation or suspension of an application for an out-of-state license or the surrender of the out-of-state license.

2. (a) No person convicted of a felony shall continue to hold a license to practice radiologic technology, unless he or she has been granted an executive pardon, a certificate of relief from disabilities or a certificate of good conduct for such felony and, the commissioner, in his or her discretion, restores the license after determining that the individual does not pose a threat to patient health and safety.

(b) A conviction of a felony shall include the conviction of a felony by any court in this state or by any court of the United States or by any court of any other state of the United States, and in the event that a crime of which the practitioner of radiologic technology is convicted by any court of the United States or any other state is not a felony in the jurisdiction in which the conviction is had but is substantially similar to a felony in the state of New York, then the conviction shall be deemed a conviction of a felony for the purpose of this article.

§ 3511. Proceedings for suspension or revocation. 1. Proceedings against any licensee under this section shall be begun by filing with the department a written charge or charges in the form of a petition under oath against such licensee. The charges may be preferred by any person, corporation, association or public officer, or by the department in the first instance.

2. If the commissioner decides that the charges should be heard, the commissioner shall appoint a hearing officer to hear and report on the charges and shall set a time and place for the hearing. A copy of the charges, together with a notice of the time and place of hearing, shall be served on the accused at least fifteen days before the date fixed for the hearing.

3. The respondent in all such cases brought under this section shall, at least five days before the return date of the petition containing the charges, file with the department a verified answer, in duplicate, to the allegations set forth in such petition. The accused shall have the opportunity at such hearing to appear either personally or by counsel, to cross-examine witnesses and to produce evidence and witnesses in his or her defense.

4. Upon the conclusion of the hearing, the hearing officer shall make a written report of findings and conclusions and shall transmit them, together with a recommendation, to the commissioner. If the accused is found not guilty by the commissioner, the commissioner shall order a dismissal of the charges and an exoneration. If the accused is found guilty of the charges, or any of them, the commissioner shall, in his or her discretion, issue an order suspending, revoking or annulling the license registration or certificate of the accused, or otherwise disciplining him or her.

5. Where the license registration or certificate of any person has been revoked or annulled, as provided in this title, the department may, after the expiration of two years, entertain an application for

restoration of such license or registration.

6. A licensee whose license registration or certificate has been suspended, revoked or annulled, or who is otherwise disciplined under this article, may commence a proceeding under article seventy-eight of the civil practice law and rules in the supreme court, Albany county, for the purpose of reviewing such determination, but no such determination shall be stayed or enjoined except after notice to the attorney general of the commencement of the proceeding.

§ 3512. Penalties. 1. It shall be a misdemeanor for a person to:

(a) sell or fraudulently obtain or furnish a radiologic technologist diploma, license, record or certificate of registration or intravenous contrast administration certificate;

(b) practice radiologic technology under cover of a diploma, license, registration or certificate illegally or fraudulently obtained or signed or issued unlawfully, or under fraudulent representation or mistake of fact in material regard;

(c) practice radiologic technology under a false or assumed name;

(d) practice or act as entitled to practice radiologic technology without a valid license or certificate, without a license appropriate to the purposes for which radiation is applied on human beings, or after having been convicted of a felony which has not been reported to the department; or

(e) otherwise violate any of the provisions of this article.

2. Such misdemeanor shall be punishable by imprisonment for not more than one year or by a fine not to exceed two thousand dollars for every such violation, or by both such fine and imprisonment for each separate violation.

3. All violations of this article, when reported to the department and duly substantiated by affidavits or other satisfactory evidence, shall be investigated and if the report is found to be true and the complaint substantiated, the department shall report such violation to the attorney general and request prompt prosecution of such violation.

4. In the prosecution of any criminal action for violation of this article by the attorney general or his or her deputy, the attorney general or his or her deputy may exercise all the powers and perform all the duties with respect to such actions or proceedings which the district attorney would otherwise be authorized or required to exercise or perform, and in such action or proceeding the district attorney shall only exercise such powers and perform such duties as are required of him or her by the attorney general or the deputy attorney general so attending.

§ 3513. Disposition of fees, fines, penalties and other moneys. 1. All fees, fines, penalties and other moneys derived from the operation of this article shall be paid to the department and shall be paid by the department to the radiological health protection account as established pursuant to chapter fifty-four of the laws of two thousand three enacting the health and mental hygiene budget.

2. Moneys received pursuant to this article may be refunded within one year from the receipt thereof on proof satisfactory to the department that:

- (a) such moneys were in excess of the amounts required by law; or
- (b) the examination for which application was made and for which a fee was paid was denied.

3. Such refund shall, upon audit and warrant of the comptroller, be paid by the department out of any moneys in the custody of the department received pursuant to this article.

§ 3514. Injunctive relief. The attorney general may apply to the supreme court within the judicial district in which a violation of this article is alleged to have occurred for an order enjoining or restraining commission or continuance of the acts complained of. Thereupon the court shall have jurisdiction of the proceeding and shall have power to grant such temporary relief or restraining order as it

deems just and proper. In any such proceeding it shall be unnecessary to allege or prove that an adequate remedy at law does not exist or that irreparable damage would result if such order were not granted. The remedy provided by this section shall be in addition to any other remedy provided by law.

TITLE IV CONSTRUCTION

Section 3515. Construction; rights of licensed radiologic technologists and exemptions from this article.

3516. Use of x-rays with respect to dental services.

3517. Separability.

§ 3515. Construction; rights of licensed radiologic technologists and exemptions from this article. 1. Nothing in the provisions of this article relating to radiologic technologists shall be construed to limit, enlarge or affect, in any respect, the practice of their respective professions by duly licensed practitioners.

1-a. (a) A radiographer who also is a specialist's assistant, as such term is defined in section thirty-seven hundred of this chapter, registered for the medical specialty of radiology, shall not: (i) render any diagnostic interpretation of any image produced by any x-ray or imaging procedure; (ii) make any diagnosis; (iii) prescribe or order any drug or drug product for which a prescription is required by any law or regulation; or (iv) order, prescribe, issue or initiate a treatment plan, a care management program or any other therapy to or for a patient unless such plan, program or other therapy has been prescribed or ordered by the supervising physician of the specialist's assistant.

(b) Paragraph (a) of this subdivision shall be inapplicable to specialist's assistants registered pursuant to law on the effective date of this subdivision; but such specialist's assistants shall continue to be subject to all of the provisions of section sixty-five hundred thirty of the education law.

2. Nothing in this article shall be construed to limit the authority of any person to administer or inject contrast media under any other law or under any rule or regulation of the commissioner, the department, the department of education or the board of regents.

3. Nothing in title eight of the education law shall be construed or applied to limit the authority of a person licensed or certified under this article to exercise the authority conferred by such license or certification under this article.

4. This article shall not be construed as applying to:

(a) a student enrolled in or attending a school or college of medicine, osteopathy, dentistry, podiatry, chiropractic, or radiologic technology who applies radiation to a human being, while under the direct supervision of a licensed physician, dentist, podiatrist, chiropractor, or radiologic technologist respectively;

(b) a person engaged in performing the duties of a radiologic technologist as defined pursuant to this article in his or her employment by an agency, bureau or division of the government of the United States;

(c) a person acting as a certified dental assistant or uncertified dental assistant who, under the supervision of a licensed dentist, operates only such radiographic dental equipment as may be prescribed by the commissioner in rules and regulations for the sole purpose of dental radiography;

(d) a person acting as a certified podiatric assistant or uncertified podiatric assistant who, under the supervision of a licensed podiatrist, operates radiographic podiatry equipment as may be prescribed by the commissioner in rules and regulations for the sole purpose of podiatric radiography; or

(e) a person issued a license as a chest radiographer prior to nineteen hundred seventy-two may use x-rays or x-ray producing equipment on human beings only as prescribed by the commissioner in rules and regulations.

§ 3516. Use of x-rays with respect to dental services. The use of

x-rays, performed in the course of dental services, shall be limited solely to diagnostic purposes and shall not be used for the purpose of verifying services performed for which requests for payment were submitted to third party payors. Nothing in this section shall limit the use of radiographic films or duplicates thereof.

§ 3517. Separability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

ARTICLE 35-A

ULTRAVIOLET RADIATION DEVICES

Section 3550. Definitions.

3551. License required.

3552. Suspension or revocation.

3553. Fees.

3554. Powers and duties of the commissioner.

3555. Restrictions on the use of ultraviolet radiation devices.

3556. Ultraviolet nail drying devices.

§ 3550. Definitions. When used in this article, the following words and phrases shall have the meanings ascribed to them in this section:

1. "Tanning facility" shall mean any establishment where one or more ultraviolet radiation device is used, offered, or made available for use by any human being, whether or not a fee is charged, directly or indirectly, but shall not include any facility where any such device is used by a qualified health care professional for treatment of medical conditions.

2. "Ultraviolet radiation device" shall mean any equipment which is designed to emit electromagnetic radiation in the wavelength interval of two hundred to four hundred nanometers in air, and which is intended to induce tanning of the human skin through irradiation, including, but not limited to, a sunlamp, tanning booth, or tanning bed.

3. "Ultraviolet nail drying device" shall mean any equipment which is designed to emit electromagnetic radiation in the wavelength interval of two hundred to four hundred nanometers in air, and which is intended to induce nail curing or hardening through irradiation.

4. "Person" shall mean an individual, corporation, partnership, joint venture, or any business entity.

§ 3551. License required. 1. On and after the effective date of this article, no person shall operate a tanning facility unless such facility is licensed as provided in this article.

2. The department shall license each applicant who submits an application on a form prescribed by the commissioner and meets the requirements of this article and any rules or regulations promulgated pursuant to this article, upon payment of a registration fee of one hundred twenty dollars.

3. The commissioner shall promulgate such rules and regulations as are necessary to effectuate the provisions of this article, including, but not limited to, establishing staggered biennial registration periods and the beginning dates thereof; assigning licensees to specific biennial registration periods through appropriate classification or grouping; setting deadline dates for making application for registration; prescribing the form and content of the license; and establishing other reasonable requirements, including appropriate proration of registration fees in connection with the initiation of a staggered biennial registration system.

4. No license issued hereunder shall be effective for more than two

years from the date of issuance.

§ 3552. Suspension or revocation. 1. The license of a tanning facility may be suspended for a fixed period, revoked or annulled, upon a finding that a licensee:

(a) is guilty of fraud or bribery in securing a license;

(b) has made any false statement as to a material matter in any application or any other statement required by this article;

(c) failed to display the license or warning signs as provided in this article; or

(d) violated any provision of this article or any rule or regulation adopted pursuant to this article.

2. In lieu of revoking, suspending or annulling a license, the department may assess a civil penalty, not exceeding two hundred fifty dollars, for a violation of any provision of this article or any rule or regulation adopted pursuant to this article.

3. Before revoking, suspending or annulling a license, or imposing any civil penalty upon a licensee, the department shall notify the licensee in writing of the proposed action and shall afford the licensee an opportunity to be heard in person or by counsel. Such notice may be served by personal delivery to the licensee or by mailing it by certified mail to the last known address on file with the department or by any method authorized by the civil practice law and rules. The hearing on such charges shall be at such time and place as the department shall prescribe.

4. The department shall have the power to suspend a license pending a hearing and to subpoena and bring before the officer or person conducting the hearing any person in the state, and administer an oath to take testimony of any person or cause his or her deposition to be taken. A subpoena issued under this section shall be subject to the provisions of the civil practice law and rules.

§ 3553. Fees. All monies collected by the department pursuant to sections thirty-five hundred fifty-one and thirty-five hundred fifty-four of this article shall be deposited into the ultraviolet radiation devices program account within the special revenue fund--other, which is hereby established. Monies in such account may be used to offset costs to the state of registering, inspecting and regulating tanning facilities.

§ 3554. Powers and duties of the commissioner. 1. The commissioner shall inspect each tanning facility licensed under this article and each ultraviolet radiation device used, offered, or made available for use in such facility, not less than biennially. The commissioner may establish a fee for such inspection, which shall not exceed two hundred dollars per ultraviolet radiation device; provided, however, that no facility shall be required to pay any such fee on more than one occasion in any biennial registration period. The commissioner may appoint and designate, from time to time, persons to make the inspections authorized by this article.

2. The commissioner shall promulgate rules and regulations to carry out the provisions of this article, including, but not limited to, regulations:

(a) requiring each tanning facility to conspicuously post the license required by this article, and appropriate warning signs as prescribed by the commissioner;

(b) requiring each tanning facility to provide informational pamphlets to customers advising of conditions, such as the use of photosensitizing drugs, under which the use of ultraviolet radiation is contraindicated;

(c) establishing standards for cleanliness, hygiene and safety; and

(d) requiring each tanning facility to provide safety goggles and any other safety-related devices to customers without additional charge therefor.

3. The commissioner may by regulation authorize any county department of health to administer this section within its jurisdiction.

§ 3555. Restrictions on the use of ultraviolet radiation devices. 1.

No owner, operator, or employee of a tanning facility shall permit the use of the tanning facility by a person eighteen years of age or older until such person provides a driver's license or other photographic identification card issued by a government entity or educational institution indicating that the individual is at least eighteen years of age and the facility has on file a signed written statement, in a form prescribed by the commissioner, acknowledging that such person has read the warnings required under subdivision two of section thirty-five hundred fifty-four of this article and agrees to wear safety goggles before using an ultraviolet radiation device. Such signed statement of acknowledgment may be retained by the tanning facility off premises provided that an electronic image or facsimile of the original signed statement of acknowledgment is readily available by the owner or employee responsible for the operation of the ultraviolet radiation device of such facility.

2. No owner, operator, or employee of a tanning facility shall permit the use of an ultraviolet radiation device by a person under eighteen years of age.

3. This section shall be exclusive and shall preempt any contrary local law or ordinance, except that this section shall not preempt or supersede local laws or ordinances imposing additional stricter restrictions on the use and operation of ultraviolet radiation devices at tanning facilities which are in effect prior to the effective date of this section.

§ 3556. Ultraviolet nail drying devices. 1. The department shall review the existing medical and scientific literature, published reports, and articles regarding the potential health hazards associated with the use of ultraviolet nail drying devices and identify any health hazards. As part of such review, the department shall consult with experts in the fields of skin cancer research and human exposure to artificial ultraviolet radiation. The department shall also review the

feasibility and effectiveness of requiring appearance enhancement businesses conducting the practice of nail specialty, as defined in subdivision four of section four hundred of the general business law, to advise users of ultraviolet nail drying devices to apply a sunscreen or a similar substance designed to block ultraviolet radiation to the hands and wrists prior to using such device.

2. Upon completion of such review, based on the findings of the department, the department of state may promulgate any regulations deemed appropriate for governing the use of ultraviolet nail drying devices by any appearance enhancement business, required to be licensed by the department of state pursuant to article twenty-seven of the general business law. If promulgated, such regulations shall include a requirement that any appearance enhancement business conducting the practice of nail specialty post a notice regarding any health hazards associated with the use of ultraviolet nail dryers and any steps users may take to mitigate such hazards in an area clearly visible to patrons in the licensed premises or in the place where the practice of an occupation licensed pursuant to article twenty-seven of the general business law is conducted.

ARTICLE 36

HOME CARE SERVICES

- Section 3600. Declaration of legislative findings and intent.
3602. Definitions.
3605. Licensure of home care services agencies.
- 3605-a. Proceedings involving the license of a home care services agency.
- 3605-b. Registration of licensed home care services agencies.
- 3605-c. Authorization to enroll and provide medical assistance.
3606. Establishment of certified home health agencies.
- 3606-a. Certified home health agency construction.
3607. Grants for expansion of services.
3608. Certification of home care services agencies.
3609. Grants for planning an establishment of new certified home health agencies.

- 3610. Authorization to provide a long term home health care program.
- 3611. Operation of home care services agency.
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- 3612. Powers and duties of commissioner and state hospital review and planning council.
- 3613. Home care services workers.
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- 3614-a. Home care provider assessments.
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- 3614-c. Home care worker wage parity.
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- 3615. State aid to certified home health agencies.
- 3616. Provision of certified home health agency services, long term home health care programs and AIDS home care programs.
- 3616-a. Quality assurance.
- 3617. Respite projects.
- 3618. Continuation of existing home health agencies.
- 3619. Exempt agencies.
- 3620. Authorization to provide an AIDS home care program.
- 3621. Payment of claims.
- 3622. Separability.

§ 3600. Declaration of legislative findings and intent. The legislature hereby finds and declares that the provision of high quality home care services to residents of New York state is a priority concern. Expanding these services to make them available throughout the state as a viable part of the health care system and as an alternative to institutional care should be a primary focus of the state's actions.

Home health care has only recently been recognized legislatively as an integral part of the health care delivery system and has proven to have an important and valuable role in patient care. The certified home health agencies render a coordinated array of services to patients in their homes, thereby avoiding prolonged institutionalization, concomitant high costs and associated adverse social and medical implications.

The legislature intends that there be a public commitment to the appropriate provision and expansion of services rendered to the residents of the state by certified home health agencies, to the maintenance of a consistently high level of services by all home care services agencies, to the central collection and public accessibility of information concerning all organized home care services, and to the adequate regulation and coordination of existing home care services.

§ 3602. Definitions. As used in this article, the following words and phrases shall have the following meanings unless the context otherwise requires:

1. "Home care services" means one or more of the following services provided to persons at home: (a) those services provided by a home care services agency; (b) home health aide services; (c) personal care services; (d) homemaker services; (e) housekeeper or chore services.

2. "Home care services agency" means an organization primarily engaged in arranging and/or providing directly or through contract arrangement one or more of the following: Nursing services, home health aide services, and other therapeutic and related services which may include, but shall not be limited to, physical, speech and occupational therapy, nutritional services, medical social services, personal care services, homemaker services, and housekeeper or chore services, which may be of a preventive, therapeutic, rehabilitative, health guidance, and/or supportive nature to persons at home.

3. "Certified home health agency" means a home care services agency

which possesses a valid certificate of approval issued pursuant to the provisions of this article, or a residential health care facility or hospital possessing a valid operating certificate issued under article twenty-eight of this chapter which is authorized under section thirty-six hundred ten of this article to provide a long term home health care program. Such an agency, facility, or hospital must be qualified to participate as a home health agency under the provisions of titles XVIII and XIX of the federal Social Security Act and shall provide, directly or through contract arrangement, a minimum of the following services which are of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home: nursing services; home health aide services; medical supplies, equipment and appliances suitable for use in the home; and at least one additional service which may include, but not limited to, the provisions of physical therapy, occupational therapy, speech pathology, nutritional services and medical social services.

4. "Home health aide services" means simple health care tasks, personal hygiene services, housekeeping tasks essential to the patient's health and other related supportive services. Such services shall be prescribed by a physician in accordance with a plan of treatment for the patient and shall be under the supervision of a registered professional nurse from a certified home health agency or, when appropriate, from a provider of a long term home health care program and of the appropriate professional therapist from such agency or provider when the aide carries out simple procedures as an extension of physical, speech or occupational therapy. Such services may also be prescribed or ordered by a nurse practitioner to the extent authorized by law and consistent with subdivision three of section six thousand nine hundred two of the education law and not prohibited by federal law or regulation.

5. "Personal care services" means services to assist with personal hygiene, dressing, feeding and household tasks essential to the patient's health. Such services shall be prescribed by a physician in accordance with a plan of home care supervised by a registered professional nurse. Such services may also be prescribed or ordered by a nurse practitioner to the extent authorized by law and consistent with

subdivision three of section six thousand nine hundred two of the education law and not prohibited by federal law or regulations.

6. "Homemaker services" means assistance and instruction in managing and maintaining a household, dressing, feeding, and incidental household tasks for persons at home because of illness, incapacity, or the absence of a caretaker relative. Such services shall be provided by persons who meet the standards established by the department of social services.

7. "Housekeeper services" or "chore services" means the provision of light work or household tasks which do not require the services of a trained homemaker. Such services may be provided for persons at home because of illness, incapacity, or the absence of a caretaker relative by persons who meet the standards established by the department of social services.

8. "Long term home health care program" means a coordinated plan of care and services provided at home to invalid, infirm, or disabled persons who are medically eligible for placement in a hospital or residential health care facility for an extended period of time if such program were unavailable.

a. Such program shall be provided in the person's home or in the home of a responsible relative or other responsible adult.

b. Such program shall be provided in adult care facilities, other than shelters for adults, certified pursuant to section four hundred sixty-b of the social services law, provided that the person meets the admission and continued stay criteria for such facility. Services provided by the program shall not duplicate or replace those which the facility is required by law or regulation to provide.

c. Approved long term home health care program providers may include, as part of their long term home health care program, upon approval by the commissioner, a discrete AIDS home care program as defined in this section.

9. "Hospital" means a hospital as defined in section twenty-eight hundred one of this chapter.

10. "Residential health care facility" means a residential health care facility as defined in section twenty-eight hundred one of this chapter.

11. "Government funds" means funds provided under the provisions of title eleven of article five of the social services law.

12. "Construction" means the addition or deletion of services offered; a change in the agency's geographic service area; the erection, building, or substantial acquisition or alteration of a physical structure or equipment; or a substantial change in the method of providing services.

13. "Licensed home care services agency" means a home care services agency, issued a license pursuant to section three thousand six hundred five of this chapter.

14. "AIDS home care program" means a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or residential health care facility and who (a) are diagnosed by a physician as having acquired immune deficiency syndrome (AIDS), or (b) are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who has an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection. Such program shall be provided only by a provider of a long term home health care program specifically authorized pursuant to this article to provide an AIDS home care program or by an AIDS center, as defined in regulations promulgated by the commissioner, specifically authorized pursuant to this article to provide an AIDS home care program. Such program shall be provided in the person's home or in the home of a responsible relative, other responsible adult, adult care facilities specifically approved to admit or retain residents for such program, or in other residential settings as approved by the commissioner in conjunction with the commissioner of social services. Such program shall

provide services including, but not be limited to, the full complement of health, social and environmental services provided by long term home health care programs in accordance with regulations promulgated by the commissioner. Such programs shall also provide such other services as required by the commissioner to assure appropriate care at home for persons eligible under this section.

* 15. "Limited home care services agency" means a certified operator of an adult home or an enriched housing program which directly provides: personal care services authorized and provided in accordance with rules and regulations of the department of social services; and the administration of medications and application of sterile dressings by a registered nurse, provided, however, that the services provided by such agency are not services that must be provided to residents of such facilities pursuant to article seven of the social services law and rules and regulations of the department of social services. Such operator may provide these services only to residents of the adult home or enriched housing program governed by the terms of such limited license.

* NB Expires June 30, 2027

16. "Public health council" and "state hospital review and planning council" shall mean the public health and health planning council.

* 17. "Advanced home health aides" means home health aides who are authorized to perform advanced tasks as delineated in subdivision two of section sixty-nine hundred eight of the education law and regulations issued by the commissioner of education relating thereto. The commissioner shall promulgate regulations regarding such aides, which shall include a process for the limitation or revocation of the advanced home health aide's authorization to perform advanced tasks in appropriate cases.

* NB Repealed March 31, 2029

§ 3605. Licensure of home care services agencies. 1. After April first, nineteen hundred eighty-six, no home care services agency which is engaged in providing, directly or through contract arrangement, nursing services, home health aide services, or personal care services

shall be operated without a license issued by the commissioner in accordance with the standards set forth in this section; provided however, an agency which provides personal care or home care services exclusively to individuals pursuant to a program administered, operated or regulated by another state agency or an organization licensed and operating exclusively as a nurses' registry pursuant to article eleven of the general business law shall be exempt from the licensure requirements of this chapter. The licensure requirements of this chapter shall not apply to sole practitioners licensed pursuant to sections six thousand nine hundred five and six thousand nine hundred six of the education law.

1-a. (a) Core public health services, as defined in section six hundred two of this chapter, when provided in the home by the local health department of a county or of the city of New York, shall not require licensure under this section if such core public services require only minimal patient contact. Patient contact shall be considered minimal if it is of limited duration for acute or non-chronic conditions, including but not limited to any health conditions posing a potential threat to public health, and treatment is generally expected to require no more than six patient visits; provided, however, that a local health department may exceed six visits in the interest of patient safety and public health.

(b) Core public health services that may be provided without a license pursuant to this subdivision include but are not limited to: immunizations; testing for tuberculosis and observation of tuberculosis self-directed therapy; verbal assessment, counseling and referral services; and such other services as may be determined by the department, provided that such services shall not include home health aide services, personal care services, or nursing services that require more than minimal patient contact.

1-b. Core public health services, as defined in section six hundred two of this chapter, when provided by local health departments in the home as authorized under subdivision one-a of this section, may be eligible for reimbursement under title XIX of the federal Social Security Act, provided that the services meet federal and state

requirements for such reimbursement.

2. The commissioner shall not issue a license to any home care services agency except with the written approval of the public health and health planning council issued pursuant to the provisions of this section.

3. An application for licensure as a home care services agency shall be filed with the public health and health planning council together with such other forms and information as shall be prescribed by, or acceptable to, the public health and health planning council. Thereafter, the public health and health planning council shall forward for comment, if any, a copy of the application for licensure and accompanying documents to the health systems agency, if any, having geographical jurisdiction of the area where the services of the proposed agency are to be offered. The public health and health planning council shall act upon such application, after the health systems agency has had reasonable time to submit its comments, based solely upon criteria provided for in subdivision four of this section. If the public health and health planning council proposes to disapprove the application, it shall notify the applicant, provide reasons for disapproval and afford the applicant a hearing on the application, if requested, or on its own motion. Any hearing held pursuant to this subdivision may be conducted by the public health and health planning council or by any individual designated by the public health and health planning council.

4. The public health and health planning council shall not approve an application for licensure unless it is satisfied as to: (a) the public need for the existence of the licensed home health care service agency at the time and place and under the circumstances proposed; (b) the character, competence and standing in the community of the applicant's incorporators, directors, sponsors, stockholders or operators; (c) the financial resources of the proposed licensed home health care service agency and its sources of financial revenues; and (d) such other matters as it shall deem pertinent.

5. A license shall not be issued by the commissioner unless he finds

that the equipment, personnel, rules, standards of care, and home care services are fit and adequate, and that the home care services will be provided in the manner required by this article and the rules and regulations thereunder.

6. Neither tax status nor profit-making status shall be criteria for licensure.

7. An agency licensed pursuant to this section shall be authorized to provide nursing services, home health aide services or personal care services.

8. Agencies licensed pursuant to this section but not certified pursuant to section three thousand six hundred eight of this article, shall not be qualified to participate as a home health agency under the provisions of title XVIII or XIX of the federal Social Security Act provided, however, an agency which has a contract with a state agency or its locally designated office or, as specified by the commissioner, with a managed care organization participating in the managed care program established pursuant to section three hundred sixty-four-j of the social services law or with a managed long term care plan established pursuant to section forty-four hundred three-f of this chapter, may receive reimbursement under title XIX of the federal Social Security Act.

* 9. An entity which seeks approval as a limited home care services agency must meet the requirements of this section, the rules and regulations of the department, and must be a certified operator of an adult home or enriched housing program pursuant to article seven of the social services law. The commissioner shall approve only those applicants that the commissioner of the department of social services has listed as eligible pursuant to the requirements of paragraph (a) of subdivision eleven of this section.

* NB Expires June 30, 2027

* 10. The department shall notify the department of social services of any action taken against a limited home care services agency pursuant to section thirty-six hundred five-a of this article.

* NB Expires June 30, 2027

* 11. For purposes of this subdivision, eligibility of limited home

care services agencies licensed by the department shall be as follows:

(a) Only those certified operators of adult homes and enriched housing programs that provide services that are consistent with the needs of each resident, meet the standards governing the operation of such facilities in accordance with the provisions of article seven of the social services law, and provide quality care shall be considered by the department as eligible for licensure.

(b) An operator that has received current official written notice from the department of social services of any enforcement action pursuant to section four hundred sixty-d of the social services law shall not be eligible for such certification.

(c) Such current enforcement action, when resolved to the satisfaction of the commissioner of social services, shall not itself preclude an otherwise eligible applicant from licensure approval but shall be considered by the department in determining the character, competence, and standing in the community of the applicant pursuant to subdivision four of this section.

(d) If the department receives notice from the department of social services that a certified operator of an adult home or enriched housing program that is licensed as a limited home care services agency has received official written notice from the department of social services of a proposed enforcement action taken pursuant to section four hundred sixty-d of the social services law, the department shall review the delivery of home care services to determine whether such agency is meeting all applicable regulations and standards.

* NB Expires June 30, 2027

* 12. Notwithstanding any law to the contrary, the commissioner shall have the authority to limit the number of adult homes and enriched housing programs eligible for licensure under this section.

* NB Expires June 30, 2027

13. The commissioner shall charge to applicants for the licensure of home care services agencies an application fee of two thousand dollars. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

14. Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after April first, two thousand fourteen, the commissioner is authorized to make temporary periodic lump-sum Medicaid payments to licensed home care service agencies ("LHCSA") principally engaged in providing home health services to Medicaid patients, in accordance with the following:

(a) Eligible LHCSA providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring;

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers; or

(v) providers seeking to ensure that access to care is maintained.

(b) Providers seeking Medicaid payments under this subdivision shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by such Medicaid payments will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested commencement of such Medicaid payments and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payments issued pursuant to this subdivision shall be made over a specified period of time, as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments shall cease. The commissioner may establish, as a condition of receiving such Medicaid payments, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the provider submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in

accomplishing such benchmarks and goals shall be a basis for ending the provider's Medicaid payments prior to the end of the specified timeframe.

(ii) The commissioner may require that applications submitted pursuant to this subdivision be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

§ 3605-a. Proceedings involving the license of a home care services agency.

1. A license of a home care services agency may be revoked, suspended, limited or annulled by the commissioner on proof that it has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

2. No such license shall be revoked, suspended, limited, annulled or denied without a hearing. However, a license may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the agency following a finding by the department that the public health or safety is in imminent danger. Notwithstanding the provisions of this section, no licensed home care services agency shall be permitted to operate unless it has registered with the department pursuant to section thirty-six hundred five-b of this article.

3. The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the agency at least twenty-one days before the date fixed for the hearing. The agency shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

4. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant or agency.

§ 3605-b. Registration of licensed home care services agencies. 1. (a) Notwithstanding any provision of law to the contrary, no licensed home care services agency (LHCSA) licensed pursuant to section thirty-six hundred five of this article shall be operated, provide nursing services, home health aide services, or personal care services, or receive reimbursement from any source for the provision of such services during any period of time on or after January first, two thousand nineteen, unless it has registered with the commissioner in a manner prescribed by the department.

(b) A LHCSA that fails to submit a complete and accurate set of all required registration materials by the deadline established by the commissioner shall be required to pay a fee of five hundred dollars for each month or part thereof that the LHCSA is in default. A LHCSA that failed to register in the prior year by the deadline of the current year shall not be permitted to register for the upcoming registration period unless it submits any unpaid late fees.

(c) The department shall post on its public website a list of all LHCSAs, which shall indicate the current registration status of each LHCSA.

(d) The department shall institute proceedings to revoke the license of any LHCSA that fails to register for two annual registration periods, whether or not such periods are consecutive. The department shall have the discretion to pursue revocation of the license of a LHCSA on grounds that it evidences a pattern of late registration over the course of multiple years.

§ 3605-c. Authorization to enroll and provide medical assistance. 1. A licensed home care services agency (LHCSA) shall not enroll as a provider in the medical assistance program operated pursuant to title eleven of article five of the social services law or provide or claim for services pursuant thereto, whether provided under the state plan, a waiver thereto or through a managed care organization, without being authorized to do so by contract with the department entered into pursuant to this section. Authorization under this section shall not

substitute for or duplicate the requirements of licensure under this article or the screening and enrollment process required for participation in the medical assistance program.

2. Notwithstanding any inconsistent provision of section one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, the commissioner shall enter into a sufficient number of contracts with LHCSAs to ensure medical assistance recipients have access to care and services, provided, however, that:

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

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

(ii) the criteria for selection of LHCSA contractors, including but not limited to: licensure under this article, the ability to appropriately serve medical assistance recipients as determined by the commissioner, a geographic distribution of LHCSAs to ensure access statewide including in rural and underserved areas, demonstrated cultural and language competencies specific to the population of recipients and those of the available workforce, ability to provide timely assistance to recipients, experience serving individuals with disabilities, efficient and economic administration of LHCSA services, and demonstrated compliance with all applicable federal and state laws and regulations including, but not limited to, past compliance with labor law and existing wage and labor standards, and compliance with equal employment opportunity requirements and anti-discrimination laws;

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

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

(b) the commissioner shall review in a timely fashion all reasonable and responsive submissions that are received from prospective contractors;

(c) the commissioner shall select such contractors that, in the

commissioner's discretion, are best suited to efficiently and economically administer medical assistance services;

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

(e) the commissioner may institute a continuous recruitment process provided that the information required under paragraph (a) of this subdivision remains on the department's website for the entire duration of the recruitment process, until such date as the commissioner may determine upon no less than ten days notice being posted on the website; and

(f) the commissioner may reoffer contracts under the same terms of this subdivision, if determined necessary by the commissioner, on a statewide or regional basis.

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

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

(ii) the time frame of the conduct that fails compliance.

(b) Notwithstanding paragraph (a) of this subdivision, upon determining that a medical assistance recipient's health or safety would be imminently endangered by the continued operation or actions of the LHCSA, the commissioner may terminate the LHCSA's contract or suspend or limit the LHCSA's rights and privileges under the contract immediately upon written notice.

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

(d) Any procedural rights or privileges afforded pursuant to this subdivision shall apply only to actions taken under this subdivision with respect to compliance with the terms of the contract. Actions taken under this subdivision shall not constitute and shall not be construed

to constitute an action with respect to a LHCSA's licensure or enrollment in the medical assistance program, which the department may undertake separately or in conjunction with an action pursuant to this subdivision.

4. The provisions of this section shall not apply unless any and all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of services that would be provided by LHCSAs in accordance with the terms of contracts entered into pursuant to this section.

§ 3606. Establishment of certified home health agencies. 1. The commissioner shall not issue a certificate of approval to any home care services agency except with the written approval of the public health and health planning council. However, a residential health care facility or hospital making application to the commissioner solely for authorization to provide a long term home health care program shall be deemed to have met such requirement, provided that the facility or hospital possesses a valid operating certificate under article twenty-eight of this chapter.

2. An application for approval of the proposed certified home health agency shall be filed with the public health and health planning council together with such other forms and information as shall be prescribed by, or acceptable to, the public health and health planning council. Thereafter, the public health and health planning council shall forward a copy of the proposed application for establishment and accompanying documents to the health systems agency, if any, having geographical jurisdiction of the area where the services of the proposed certified home health agency are to be offered. The public health and health planning council shall act upon such application after the health systems agency has had a reasonable time to submit its recommendations. At the time members of the public health and health planning council are notified that an application is scheduled for consideration, the applicant and the health systems agency shall be so notified in writing. The public health and health planning council shall not take any action

contrary to the advice of the health systems agency until it affords to the health systems agency an opportunity to request a public hearing and, if so requested, a public hearing shall be held. If the public health and health planning council proposes to disapprove the application it shall afford the applicant an opportunity to request a public hearing. The public health and health planning council may hold a public hearing on the application on its own motion. Any public hearing held pursuant to this subdivision may be conducted by the public health and health planning council or by any individual designated by the public health and health planning council.

The public health and health planning council shall not approve an application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the certified home health agency at the time and place and under the circumstances proposed; (b) the character, competence, and standing in the community, of the proposed incorporators, directors and sponsors; (c) the financial resources of the proposed certified home health agency and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

Neither the tax status nor profit-making status of proposed certified home health agencies shall be criteria for establishment.

3. An application for establishment by a home care services agency in existence and operating on the effective date of this section shall be acted upon by the public health council within twelve months of the submission of such application.

4. (a) The commissioner shall charge to applicants for the establishment of certified home health agencies an application fee of two thousand dollars.

(b) An applicant for both establishment and construction of a certified home health agency shall not be subject to this subdivision and shall be subject to fees and charges as set forth in section thirty-six hundred six-a of this article.

(c) The fees and charges paid by an applicant pursuant to this

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

§ 3606-a. Certified home health agency construction. 1. The construction of a certified home health agency shall require the prior approval of the commissioner.

2. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the public health and health planning council and the health systems agency, if any, having geographical jurisdiction of the area where the agency is located.

3. The commissioner shall not act upon an application for construction unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health and health planning council pursuant to the provisions of this article) and until the public health and health planning council and the health systems agency, if any, concerned have had a reasonable time to submit their recommendations; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed.

4. Subject to the provisions of paragraph (b) of subdivision three of this section, the commissioner in approving the construction shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services which currently serve as alternatives or substitutes for the whole or any part of the proposed construction;

(b) the need for program changes in view of existing utilization at

the time and place and under the circumstances proposed; and

(c) the adequacy of financial resources and sources of future revenue.

5. In determining whether there is a public need for the proposed construction pursuant to subdivisions three and four of this section, the commissioner shall consider the advice of the state health planning and development agency designated pursuant to the provisions of the national health planning and resources development act of nineteen hundred seventy-four and any amendments thereto.

6. No government agency shall construct any certified home health agency without securing the written approval of the commissioner in accordance with the applicable requirements and procedures of the preceding subdivisions.

7. If the commissioner proposes to disapprove an application for construction of a certified home health agency, he shall afford the applicant an opportunity to request a public hearing. The commissioner shall not take any action contrary to the advice of the health systems agency until he affords an opportunity to the agency to request a public hearing and, if so requested, a public hearing shall be held.

8. The commissioner, on his own motion, may hold a public hearing on an application for construction of a certified home health agency.

9. (a) The commissioner shall charge to applicants for construction of certified home health agencies an application fee of two thousand dollars. Each such applicant shall, at such time as the commissioner's written approval of the construction is granted, pay an additional fee of thirty hundredths of one percent of the total capital value of the application.

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

339, certificate of need account.

§ 3607. Grants for expansion of services. 1. The commissioner is hereby authorized, within the amount allocated pursuant to subdivisions one, two and three of section thirty-six hundred fifteen of this article, to make grants to certified public and voluntary non-profit home health agencies for the purpose of increasing the availability of home health care services. Such grants shall be utilized to increase the number of persons provided services, the kind of services provided, including medical, social and environmental services, the sharing of services or to improve or expand the method or frequency of the delivery of home health care services. Grant applications shall include specific plans to provide the following:

a. an expansion of the types of services made available to persons at home as provided for in subdivision two of section thirty-six hundred two of this chapter;

b. an increase in the number of persons provided home care services by the certified home health agency, directly or through contractual arrangement, or to provide for the availability of certified home health agency services on a seven-day-a-week basis;

c. the development of training programs approved by the commissioner to improve the quality of services provided by the certified home health agency;

d. the development of programs to coordinate the work of the certified home health agency with other community resources, including but not limited to other certified home health agencies, hospitals, and social services agencies;

e. demonstration projects to provide care in the home by using methods, programs, or arrangements not ordinarily used by certified home health agencies, and that will help to determine the most appropriate means of reducing institutional care and of providing better quality

home care services, most cost-effective home care services, and more accessible home care services;

f. the development of programs to improve home care patients' access to primary health services; or

g. the development of "home care volunteer programs for maternal and child health" pursuant to subdivision two of this section.

2. a. For purposes of this section, "home care volunteer program for maternal and child health" shall mean a program developed, coordinated and provided by a certified home health agency for purposes of assisting pregnant women and children. Such assistance shall include but not be limited to: guidance in self care related to prenatal care and post partum care such as information concerning proper nutrition, exercise, hygiene, drug, tobacco and alcohol use, and breast feeding; guidance in infant care; friendly visiting; and telephone reassurance. Such assistance may also include home maintenance, child care and shopping. Additional services which the agency may provide in conjunction with the program shall include nursing, social work, home health aide and other approved agency services necessary to serve this population.

b. In providing such program, a certified home health agency shall utilize volunteers, especially women who have had children and who are willing and able to provide non-medical assistance to women for prenatal care and infant care.

c. The certified home health agency shall recruit, train and supervise volunteers for the program and shall assure that such volunteers are competent to perform the required tasks and are suited to the client. The agency shall designate a person responsible for management of the program.

d. Certified home health agencies which provide home care volunteer programs for maternal and child health shall establish provisions for referral and case coordination with prenatal care providers as defined in section three hundred sixty-five-k of the social services law.

3. A public or voluntary non-profit certified home health agency may make application for such grant in the manner and form prescribed by the commissioner. Grant applications may be made for up to a three-year period; however, grant awards shall be for one-year periods, subject to annual renewal upon approval by the commissioner.

4. A grant amount available under this program shall not exceed the total cost of providing the additional services, as specified in the application, less any income from governmental, third party or any other sources accruing as a result of the provision of such additional services. Grants may not be used for agency capital construction purposes. The initial grant and first year renewal may be no more than one hundred percent of the net cost of providing such additional services. Any grants provided for a third year shall be no more than seventy-five percent of the initial year's grant. No grant shall exceed one hundred thousand dollars per annum.

5. A grantee must certify to the commissioner that all available reimbursement for services has been and will be sought. To be eligible for a renewal grant, the level and amount of services provided during any previous grant period may not be decreased without the prior approval of the commissioner, and the grantee shall identify and certify that sufficient funds are available to maintain previous levels and amounts of service.

6. In awarding grants pursuant to this section, the commissioner and the advisory group established pursuant to subdivision six of section thirty-six hundred fifteen of this article shall take into consideration, in relation to the area served, the following factors: the number of patients awaiting discharge from hospitals or residential health care facilities for whom home care services are appropriate, the proportion of patients inappropriately placed in hospitals and residential health care facilities who could be served by in-home care, the scope, quantity and accessibility of currently available home health services, the ability of the agency to continue the expanded services upon expiration of the grant, and such other factors as the commissioner

may determine are relevant to the public need for home health services.

7. In addition to the requirements of this section, the commissioner shall approve grant applications in accordance with the provisions of subdivisions five, six and seven of section thirty-six hundred fifteen of this article.

8. Funds for such grants shall be made available pursuant to the funding formula and allocations provided in subdivisions one, two and three of section thirty-six hundred fifteen of this article.

9. The commissioner, shall promulgate rules and regulations necessary to administer this section.

§ 3608. Certification of home care services agencies. 1. The commissioner shall issue a certificate of approval to any home care services agency qualified to participate as a home health agency under titles XVIII and XIX of the federal Social Security Act applying therefor which complies with the provision of this article and the rules and regulations promulgated pursuant thereto, in accordance with the standards and procedures adopted by the state hospital review and planning council.

2. A certified home health agency certificate of approval may be revoked, suspended, limited or annulled by the commissioner on proof that the certified home health agency has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

3. No certified home health agency certificate of approval shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the certified home health agency following a finding by the department that the public health or safety is in imminent danger.

4. The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the certified home health agency at least twenty-one days before the date fixed for the hearing. The certified home health agency shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

5. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant.

6. (a) Notwithstanding the provisions of subdivisions three through five of this section, the commissioner shall suspend, limit or revoke a certified home health agency certificate of approval after taking into consideration the public need for the agency and the availability of other services which may serve as alternatives or substitutes, and after finding that suspending, limiting, or revoking the certificate of approval of such agency would be within the public interest in order to conserve health resources by restricting the level of services to those which are actually needed.

(b) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular certified home health agency, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of the agency, at least thirty days prior to making such a finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(c) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any certified home health agency, cause such agency and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action to revoke, suspend or limit such agency's

certificate of approval. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the certified home health agency or the appropriate health systems agency may request a public hearing to be held in the county in which the agency is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(d) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

§ 3609. Grants for planning an establishment of new certified home health agencies. 1. The commissioner is hereby authorized, within the amount allocated pursuant to subdivisions one, two and three of section thirty-six hundred fifteen of this article, to make grants to voluntary not-for-profit organizations in areas of the state determined by the commissioner to be in need of home care services.

2. Such grants shall be awarded for the purposes of planning for establishment as a certified home health agency pursuant to section thirty-six hundred six of this chapter.

3. Such grants shall not exceed twenty thousand dollars per annum and are not renewable.

4. The grant applications shall include such information as required by the commissioner.

5. Funds for such grants shall be made available pursuant to the funding formula and allocations as provided in subdivisions one, two and three of section thirty-six hundred fifteen of this article.

6. The commissioner shall approve applications in accordance with the provisions of subdivisions five, six and seven of section thirty-six hundred fifteen of this article.

§ 3610. Authorization to provide a long term home health care program.

1. A long term home health care program may be provided only by a certified home health agency, or by a residential health care facility or hospital possessing a valid operating certificate issued under article twenty-eight of this chapter. No agency, facility or hospital shall provide a long term home health care program without the written authorization of the commissioner to provide such a program.

2. A hospital, residential health care facility, or certified home health agency seeking authorization to provide a long term home health care program shall transmit to the commissioner an application setting forth the scope of the proposed program. Such application shall be in a format and shall be submitted in a quantity determined by the commissioner. The commissioner shall transmit the application to the public health and health planning council and to the health systems agency, if any, having geographic jurisdiction of the area where the proposed program is to be located. The application shall include a detailed description of the proposed program including, but not limited to, the following:

- (a) an outline of the institution's or agency's plans for the program;
- (b) the need for the proposed program;
- (c) the number and types of personnel to be employed;
- (d) the ability of the agency, hospital, or facility to provide the program;
- (e) the estimated number of visits to be provided;
- (f) the geographic area in which the proposed programs will be provided;
- (g) any special or unusual services, programs, or equipment to be provided;
- (h) a demonstration that the proposed program is feasible and adequate in terms of both short range and long range goals;
- (i) such other information as the commissioner may require.

The health systems agency and the public health and health planning council shall review the application and submit their recommendations to the commissioner. At the time members of the public health and health planning council are notified that an application is scheduled for consideration, the applicant and the health systems agency shall be so notified in writing. The health systems agency or the public health and health planning council shall not recommend approval of the application unless it is satisfied as to:

- (a) the public need for the program at the time and place and under the circumstances proposed;

- (b) the financial resources of the provider of the proposed program and its sources of future revenues;

- (c) the ability of the proposed program to meet those standards established for participation as a home health agency under title XVIII of the federal Social Security Act; and

- (d) such other matters as it shall deem pertinent.

After receiving and considering the recommendations of the public health and health planning council and the health systems agency, the commissioner shall make his or her determination. The commissioner shall act upon an application after the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations. The commissioner shall not take any action contrary to the advice of either until he or she affords to either an opportunity to request a public hearing and, if so requested, a public hearing shall be held. The commissioner shall not approve the application unless he or she is satisfied as to the detailed description of the proposed program and

- (a) the public need for the existence of the program at the time and place and under the circumstances proposed;

- (b) the financial resources of the provider of the proposed program and its sources of future revenues;

- (c) the ability of the proposed program to meet those standards established for participation as a home health agency under title XVIII of the federal Social Security Act; and

- (d) such other matters as he or she shall deem pertinent.

If the application is approved, the applicant shall be so notified in writing. The commissioner's written approval of the application shall constitute authorization to provide a long term home health care program. If the commissioner proposes to disapprove the application, he or she shall notify the applicant in writing, stating his or her reasons for disapproval, and afford the applicant an opportunity for a public hearing.

3. Authorization to provide a long term home health program may be revoked, suspended, limited or annulled by the commissioner on proof that a provider of a long term home health care program has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

4. (a) Such authorization shall not be revoked, suspended, limited or annulled without a hearing. However, such authorization may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the provider of a long term home health care program following a finding by the department that the public health or safety is in imminent danger.

(b) The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the provider of a long term home health care program at least twenty-one days before the date fixed for the hearing. Such provider shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(c) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant.

5. (a) Notwithstanding the provisions of subdivision four of this section, the commissioner shall suspend, limit or revoke the authorization of a provider of a long term home health care program

after taking into consideration the public need for the program and the availability of other services which may serve as alternatives or substitutes, and after finding that suspending, limiting, or revoking the authorization of such provider would be within the public interest in order to conserve health resources by restricting the level of services to those which are actually needed.

(c) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular provider of a long term home health care program, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of such provider, at least thirty days prior to making such a finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(d) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any provider of a long term home health care program, cause such provider and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the provider or the appropriate health systems agency may request a public hearing to be held in the county in which the provider is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(e) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

6. (a) The commissioner shall charge to applicants for the authorization or construction of long term home health care programs an application fee of two thousand dollars. Each such applicant shall, at

such time as the commissioner's written approval of a construction application is granted, pay an additional fee of thirty hundredths of one percent of the total capital value of the application.

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

§ 3611. Operation of home care services agency. 1. Any home care services agency which seeks licensure pursuant to section three thousand six hundred five of this chapter or a certificate of approval pursuant to section three thousand six hundred six of this chapter and which would be operated by a person, partnership, limited liability company, or a corporation any of the members of which are not natural persons or which would be operated by a corporation any of the stock of which is owned by another corporation shall:

(a) establish a corporation or limited liability company within the state;

(b) submit to a character and competence review of any stockholder or member holding ten percent or more of the stock in said corporation or limited liability company, as well as of any parent or health related subsidiary corporation;

(c) grant authority to the New York state corporation or limited liability company to have full legal authority over the operation of the home health services agency;

(d) disclosure of information relative to stockholders or members as may be required by the commissioner to determine character and competence; and

(e) designate an agent for service of process pursuant to section three hundred five of the business corporation law or section three hundred two of the limited liability company law, as the case may be.

2. The public health and health planning council shall not act upon an

application for licensure or a certificate of approval for any agency referred to in subdivision one of this section unless it is satisfied as to the character, competence and standing in the community of the proposed incorporators, directors, sponsors, controlling persons, principal stockholders of the parent corporation, health related subsidiary corporation and the New York state corporation established pursuant to paragraph (a) of subdivision one of this section. For the purposes of this section the public health and health planning council may adopt rules and regulations relative to what constitutes parent and subsidiary corporations.

§ 3611-a. Change in the operator or owner. 1. Any change in the person who, or any transfer, assignment, or other disposition of an interest or voting rights of ten percent or more, or any transfer, assignment or other disposition which results in the ownership or control of an interest or voting rights of ten percent or more, in a limited liability company or a partnership which is the operator of a licensed home care services agency or a certified home health agency shall be approved by the public health and health planning council, in accordance with the provisions of subdivision four of section thirty-six hundred five of this article relative to licensure or subdivision two of section thirty-six hundred six of this article relative to certificate of approval, except that:

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

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

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

(i) an interest or voting rights to any person previously approved by the public health and health planning council, or its predecessor, for that operator; or

(ii) an interest or voting rights of less than ten percent in the

operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the partner or member completes and files with the public health and health planning council notice on forms to be developed by the public health council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction.

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

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

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

(c) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition of an interest or voting rights to any person previously approved by the public health and health planning council, or its predecessor, for that operator. However, no such transaction shall be effective unless at

least one hundred twenty days prior to the intended effective date thereof, the partner or member completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction.

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

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

§ 3612. Powers and duties of commissioner and state hospital review and planning council. 1. The commissioner shall have the power to conduct periodic inspections of facilities of certified home health agencies, providers of long term home health care programs and of providers of AIDS home care programs with respect to the fitness and adequacy of equipment, personnel, rules and bylaws, standards of service and medical care, system of accounts, records, and the adequacy of financial resources and sources of future revenues.

2. The commissioner shall have the power to conduct periodic inspections of licensed home care services agencies with respect to the standards of service and care, qualifications of personnel and the clinical records maintained by such agency.

3. Any organization which provides or makes available any home care services to the public in this state, in any organized program developed or rendered under its auspices or provided under contract with any such organization, shall submit annually to the commissioner a complete description of its operation, including name, address, location or principal place of business, ownership, identification of administrative personnel responsible for home care services programs, the nature and extent of such programs, and such other information as the commissioner shall require. For certified home health agencies and licensed home care services agencies such annual report shall include reports on the type, frequency and reimbursement for services provided, including reimbursement from federal and state governmental agencies. The commissioner shall determine the form and content of the information compiled and the annual date for submission of such information. The commissioner shall require certified home health agencies to provide all information necessary to a licensed home care services agency sub-contracting with such certified home health agency, to allow such licensed home care services agency to file its annual report. The commissioner shall make such information available to the appropriate governmental agencies of the state, the counties and the city of New York so as to make known the availability of home care services to provide data for planning for health needs of the people of the state. This information shall be available to the public and to the health systems agencies.

4. The commissioner shall establish within the department a unit for home care services to assist him in carrying out the provisions of this article.

5. The public health and health planning council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article with respect to certified home health agencies, providers of long term home health care programs and providers of AIDS home care programs, including, but not limited to, (a) the establishment of requirements for a uniform statewide system of reports and audits

relating to the quality of services provided and their utilization and costs; (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges; (c) standards and procedures relating to certificates of approval and authorization to provide long term home health care programs and AIDS home care programs; (d) uniform standards for quality of care and services to be provided by certified home health agencies, providers of long term home health care programs and providers of AIDS home care programs; (e) requirements for minimum levels of staffing, taking into consideration the size of the agency, provider of a long term home health care program or provider of an AIDS home care program, the type of care and service provided, and the special needs of the persons served; (f) standards and procedures relating to contractual arrangements between home care services agencies; (g) requirements for the establishment of plans for the coordination of home care services and discharge planning for former patients or residents of facilities under the regulatory jurisdiction of the department, the departments of social services or mental hygiene, the board of social welfare, or the office for the aging; (h) requirements for uniform review of the appropriate utilization of services; and (i) requirements for minimum qualifications and standards of training for personnel as appropriate. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

6. The commissioner shall adopt rules and regulations for licensed home care services agencies which establishes a cap on administrative and general costs for such agencies equal to the cap on administrative and general costs applied to certified home health agencies in accordance with subdivision seven of section thirty-six hundred fourteen of this article.

7. The commissioner shall adopt and may amend rules and regulations to effectuate the provisions and purposes of this article as to licensed home care services agencies with regard to (a) uniform standards for quality of care and services to be provided and (b) the establishment of a uniform statewide system of reports relating to the quality of services offered.

8. (a) The commissioner may require a health home or licensed home care services agency to report on the costs incurred by the health home or licensed home care services agency in rendering health care services to Medicaid beneficiaries. The department of health may specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation, provided, however, that the department shall provide no less than ninety calendar days' notice before such reports are due.

(b) If the department determines that the cost report submitted by a provider is inaccurate or incomplete, the department shall notify the provider in writing and advise the provider of the correction or additional information that the provider must submit. The provider must submit the corrected or additional information within thirty calendar days from the date the provider receives the notice.

(c) The department shall grant a provider an additional thirty calendar days to submit the original, corrected or additional cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date due for reasons beyond the provider's control.

(d) All reports shall be certified by the owner, administrator, chief executive officer, or public official responsible for the operation of the provider. The cost report form shall include a certification form, which shall specify who must certify the report.

§ 3613. Home care services workers. 1. As used in this section, the following terms shall have the following meanings:

* (a) "Home care services entity" means a home care services agency or other entity providing home care services subject to this article or exempt under section thirty-six hundred nineteen of this article, or an enhanced assisted living residence licensed under article seven of the social services law and certified under article forty-six-B of this chapter providing enhanced assisted living services. A hospice program under article forty of this chapter providing hospice care in a patient's home shall be considered a home care services entity only for

the purpose of compliance with the home care services worker registry.

* NB Effective until March 31, 2029

* (a) "Home care services entity" means a home care services agency or other entity providing home care services subject to this article or exempt under section thirty-six hundred nineteen of this article.

* NB Effective March 31, 2029

(b) "Home care services worker" or "worker" means any person engaged in or applying to become engaged in providing home health aide services, as defined in subdivision four of section three thousand six hundred two of this article or "personal care services", as defined in subdivision five of section three thousand six hundred two of this article.

(c) "Home care services worker registry" or "registry" means the home care services worker registry established by this section.

(d) "State-approved education or training program" or "program" means a program that provides education or training for persons to meet any requirement established by the department for providing home health aide services or personal care services, which program is approved by the department or the state education department.

1-a. Each home care services worker shall obtain an individual unique identifier from the state by or before a date determined by the commissioner in consultation with the Medicaid inspector general. Any personal information submitted to obtain such unique identifier shall be maintained as confidential pursuant to article six-A of the public officers law ("New York state privacy protection law").

2. The department shall develop and maintain a home care services worker registry of persons who have successfully completed a state-approved education or training program. Information in the registry shall be readily accessible on the department's website by the public, home care services workers, and home care services entities, subject to subdivision seven of this section. A home care services entity shall obtain information relating to a home care services worker, pursuant to paragraph (c) of subdivision seven of this section, prior to the worker beginning to provide home care services for that entity, except that a home care services worker employed by any entity prior to the effective date of this section may provide home care services as

provided in subdivision eight of this section. No employer of a home care services worker other than a home care services entity shall be required to obtain information from the registry.

3. The registry shall include, but not be limited to, the following information concerning each person who has successfully completed a state-approved education or training program that is listed in the registry:

(a) Full name, including pre-marital name and any other names currently or previously used;

(b) Current home address;

(c) Gender;

(d) Date of birth;

(e) Name of each state-approved education or training program successfully completed, the name of the entity providing the program, and the date on which the program was completed;

(f) History of work in home care services through any home care services entity, including dates of employment and name of entity providing the employment;

(g) Final findings made in accordance with the provisions of statutorily established proceedings subject to the state administrative procedure act or other similar law, that the person engaged in physical abuse, mistreatment, neglect or misappropriation of a patient's property, while serving the patient as a home care services worker or in another capacity, the name of the governmental agency, case number if a number is assigned, and date of determination, together with any statement concerning such determination submitted by the person, that may not identify any other person and may not exceed one hundred fifty words; and

(h) A record of any determination of the department regarding the approval or disapproval of a prospective employee pursuant to subdivision five of section eight hundred forty-five-b of the executive law, together with any statement concerning such determination submitted by the person, that may not identify any other person and may not exceed one hundred fifty words.

4. The registry shall include a comprehensive list of all

state-approved education or training programs. The list shall be updated at least monthly by the department and the state education department. The respective departments shall promptly submit updated information whenever such information changes.

5. (a) The department shall specify which information for the registry shall be submitted and updated by the state-approved education or training program, home care services worker and home care services entity, subject to the provisions of this subdivision.

(b) Any entity that offers or provides a state-approved education or training program shall provide the department the following documentation for every person who successfully completes any program provided by the entity, in the form and manner provided by the department:

(i) a written sworn statement by the senior official of the entity that offers or provides such program, made under penalty of perjury, certifying that each person has in fact successfully completed the identified program, identifying each such person by name, address, date of birth and date on which such program was completed, and describing the nature of the education or training covered in such program; and

(ii) proof that such entity has verified the true identity of each person who has successfully completed the identified program.

(c) A home care services worker employed by a home care services entity shall only be required to provide for the registry that information specified in paragraphs (a), (b), (c), (d) and (e) of subdivision three of this section, and, to the best of their knowledge and recollection, paragraph (f) of subdivision three of this section.

(d) The registry shall be updated at least monthly. Any person or entity required or choosing to provide information to the registry shall promptly submit updated information whenever such information changes.

6. No charges shall be imposed on any person or entity for any costs related to the registry.

7. (a) Members of the public may access and obtain information in the registry through the department's website, except information specified in paragraphs (b) and (d) of subdivision three of this section. The

department shall also provide toll-free telephone access for members of the public to access and obtain information from the registry, except information specified in paragraphs (b) and (d) of subdivision three of this section.

(b) A home care services worker may access or obtain any information in the worker's own listing in the registry.

(c) A home care services entity may access or obtain any information in the registry relating to any home care services worker the entity engages or is considering engaging to provide home care services.

(d) The department shall include security mechanisms in the registry to implement this subdivision and to maintain a record of accessing or obtaining information from the registry by every home care services entity.

7-a. The department shall make the contact details of department-approved education or training programs that offer competency exams to home health aides available on the department's website and readily accessible by the public.

8. The department shall provide reasonable and appropriate timetables, notices and phase-in mechanisms for applying various provisions of this section to state-approved education and training programs, home care services entities, persons becoming home care services workers and persons already engaged as home care services workers. Persons employed as home care services workers on the effective date of this section shall be registered as soon as practicable, but not later than twelve months after such effective date.

* 9. The department shall indicate within the home care services worker registry when a home health aide has satisfied all applicable training and recertification requirements and has passed the applicable competency examinations necessary to perform advanced tasks pursuant to subdivision two of section sixty-nine hundred eight of the education law and regulations issued thereto. Any limitation or revocation of the advanced home health aide's authorization also shall be indicated on the registry.

* NB Effective until March 31, 2029

* 9. The commissioner shall make rules and regulations reasonably

necessary to implement the provisions of this section.

* NB Effective March 31, 2029

* 10. The commissioner shall make rules and regulations reasonably necessary to implement the provisions of this section.

* NB Effective until March 31, 2029

§ 3614. Payments for certified home health agency services, long term home health care programs and AIDS home care programs. 1. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for services provided by a home care services agency, a provider of a long term home health care program or a provider of an AIDS home care program unless, at the time the services were provided, the home care services agency possessed a valid certificate of approval or the provider of a long term home health care program or AIDS home care program had been authorized by the commissioner to provide such program. However, contractual arrangements between a certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency and any home care services agency shall not be prohibited, provided that the certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency maintains full responsibility for the plan of treatment and the care rendered.

2. Payments for certified home health agency services or services provided by long term home health care programs or AIDS home care programs made by government agencies shall be at rates approved by the state director of the budget. No provider of a long term home health care program or AIDS home care program shall establish charges for such program in excess of those established pursuant to the provisions of this section and rules and regulations adopted pursuant to section thirty-six hundred twelve of this article or subchapter XVIII of the federal Social Security Act (Medicare).

2-a. Notwithstanding any contrary law, rule or regulation, for rate periods on and after April first, two thousand eleven, Medicaid rates of payments for services provided by certified home health agencies, by

long term home health care programs or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

3. Prior to the approval of such rates, the commissioner shall determine and certify to the state director of the budget that the proposed rate schedules for payments for certified home health agency services or services provided by long term home health care programs or AIDS home care programs are reasonably related to the costs of the efficient production of such services. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the certified home health agency, provider of a long term home health care program or provider of an AIDS home care program is located, costs of certified home health agencies, providers of long term home health care programs or providers of AIDS home care programs of comparable size, and the need for incentives to improve services and institute economies.

3-a. Medically fragile children and medically fragile adults. Rates of payment for continuous nursing services for medically fragile children and medically fragile adults provided by a certified home health agency, a licensed home care services agency or a long term home health care program shall be established to ensure the availability of such services, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies or programs, and shall be established at a rate that is at least equal to rates of payment for such services rendered to patients eligible for AIDS home care programs; provided, however, that a certified home health agency, a licensed home care services agency or a long term home health care program that receives such enhanced rates for continuous nursing services for medically fragile children and medically fragile adults shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. In the case of services provided by certified home health agencies and long term home health care programs through contracts with licensed home care services

agencies, rate increases received by such certified home health agencies and long term home health care programs pursuant to this subdivision shall be reflected in payments made to the registered nurses or licensed practical nurses employed by such licensed home care services agencies to render services to these children and medically fragile adults. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children and medically fragile adults in a non-institutional setting as compared to an institutional setting. For the purposes of this subdivision, a medically fragile child shall mean a child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case management services and continuous nursing services. The commissioner shall promulgate regulations to implement provisions of this subdivision and may also direct the providers specified in this subdivision to provide such additional information and in such form as the commissioner shall determine is reasonably necessary to implement the provisions of this subdivision.

3-c. Home telehealth. (a) Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term home health care program or AIDS home care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement for telehealth services provided pursuant to this section shall be provided only in connection with Federal Food and Drug Administration-approved and interoperable devices, and incorporated as part of the patient's plan of care. The commissioner shall seek federal financial participation with regard to this

demonstration initiative.

(b) The purposes of such services shall be to assist in the effective monitoring and management of patients whose medical, functional and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention. Reimbursement provided pursuant to this subdivision shall be for services to patients with conditions or clinical circumstances associated with the need for frequent monitoring, and/or the need for frequent physician, skilled nursing or acute care services, and where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admissions. Such conditions and clinical circumstances shall include, but not be limited to, congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

(c) Demonstration rates or fees established by the commissioner and approved by the director of the budget, for such telehealth services shall reflect telehealth services costs on a monthly basis in order to account for daily variation in the intensity and complexity of patients' telehealth service needs; provided that such demonstration rates shall further reflect the cost of the daily operation and provision of such services, which costs shall include the following functions undertaken by the participating certified home health agency, long term home health care program, AIDS home care program or licensed home care services agency:

(i) Monitoring of patient vital signs;

(ii) Patient education;

(iii) Medication management;

(iv) Equipment maintenance;

(v) Review of patient trends and/or other changes in patient condition necessitating professional intervention; and

(vi) Such other activities as the commissioner may deem necessary and appropriate to this section.

(d) The commissioner shall take such additional steps as may be reasonably necessary to implement the provision of this subdivision;

provided however that the commissioner shall establish initial demonstration rates or fees for telehealth services as provided for in this subdivision by no later than October first, two thousand seven; and provided, further, however, that the commissioner shall seek the input of representatives from participating providers and other interested parties in the development of such rates or fees and any applicable requirements established pursuant to this subdivision.

(e) The commissioner shall, within monies appropriated therefor, establish a rural home telehealth delivery demonstration study program in counties having a population of not less than one hundred thirty thousand and not more than one hundred forty thousand, according to the two thousand ten decennial federal census. The commissioner shall direct a home health organization serving in such county to study patients receiving telehealth services, pursuant to this subdivision, who have been diagnosed with congestive heart failure, diabetes and/or chronic pulmonary obstructive disease, and whose medical, functional and/or environmental needs are appropriately met at home through the application of telehealth services interventions. Such a study shall determine the cost of providing telehealth services, the quality of care provided through telehealth services and the outcomes of patients receiving such telehealth services. The commissioner shall reimburse the home health organization for conducting the study with amounts appropriated under this subdivision. The home health organization shall evaluate the findings of the study and report to the governor, the temporary president of the senate, the speaker of the assembly, the commissioner, and the chair of the legislative commission on rural resources on its findings of providing telehealth services for each condition, so as to provide the cost benchmarks with and without telehealth care, as well as providing cost benefit measurements in terms of the quality benefit outcomes for each of the conditions addressed via telehealth.

4. The commissioner shall notify each certified home health agency, long term home health care program and AIDS home care program of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least thirty days prior to the beginning of an

established rate period for which the rate is to become effective. Such notification shall be made only after approval of rate schedules by the state director of the budget.

* 5. (a) During the period July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety, the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one and for each calendar year period commencing on January first thereafter, rates of payment by governmental agencies established in accordance with subdivision three of this section applicable for services provided by certified home health agencies to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for certified home health agencies which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during the base year period as used in determining such rates may include an allowance determined in accordance with this subdivision to reflect the needs of the certified home health agency for the financing of losses resulting from bad debt and the cost of charity care. Losses resulting from bad debt and the delivery of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the certified home health agency and the availability of other financial support, including state local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the certified home health agency. The bad debt and charity care allowance for a certified home health agency for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. For purposes of distribution of bad debt and charity care allowances to eligible certified home health agencies, the commissioner, in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, may limit application of a bad debt and charity care allowance to a particular home care services unit

or units of service, such as nursing service. A certified home health agency applying for a bad debt and charity care allowance pursuant to this subdivision shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this subdivision, a certified home health agency shall: have professional assistance available on a seven day per week, twenty-four hour per day basis to all registered clients; demonstrate compliance with minimum charity care certification obligation levels established pursuant to rules and regulations adopted by the state hospital review and planning council and approved by the commissioner; and provide to the commissioner and maintain a community service plan which outlines the agency's organizational mission and commitment to meet the home care needs of the community, in accordance with paragraph (h) of this subdivision.

(b) The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible certified home health agencies for a rate period in accordance with this subdivision shall be limited to an annual aggregate amount of six million two hundred fifty thousand dollars; provided, however, that the amount of funds allocated for distribution to eligible publicly sponsored certified home health agencies for bad debt and charity care allowances shall not exceed thirty-five percent of total available funds for all eligible certified home health agencies for bad debt and charity care allowances. In establishing an apportionment of available funds to publicly sponsored certified home health agencies in accordance with this paragraph, the commissioner shall promulgate regulations which may include, but not be limited to, such factors as the ratio of public to nonpublic base year period bad debt and charity care provided by eligible certified home health agencies and differences in costs for delivering such services. Certified home health agencies provided by general hospitals shall not be eligible for any portion of the allocation pursuant to this paragraph for the period of July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety-four, or for such longer period if extended by law, based on the projected availability of an equitable

level of bad debt and charity care coverage for such agencies provided pursuant to chapter two of the laws of nineteen hundred eighty-eight and any future amendments thereto.

(c) No certified home health agency may receive a bad debt and charity care allowance in accordance with this subdivision in an amount which exceeds its need for the financing of losses associated with the delivery of bad debt and charity care.

(d) A nominal payment amount for the financing of losses associated with the delivery of bad debt and charity care will be established for each eligible certified home health agency. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of bad debt and charity care for percentage increases in the relationship between base year period losses associated with the delivery of bad debt and charity care and base year period total operating costs according to the following scale:

% of bad debt and charity care losses to total operating cost	nominal percentage of loss coverage
Up to 3%	50%
3 - 6%	75%
6% +	100%

If the sum of the nominal payment amounts for all eligible voluntary non-profit and private proprietary certified home health agencies or for all eligible public certified home health agencies is less than the amount allocated for bad debt and charity care allowances pursuant to paragraph (b) of this subdivision for such certified home health agencies respectively, the nominal coverage percentages of base year period losses associated with the delivery of bad debt and charity care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit and private proprietary certified home health agencies or for public certified home health agencies in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner.

(e) The bad debt and charity care allowance for each eligible voluntary non-profit and private proprietary certified home health agency shall be based on the dollar value of the result of the ratio of

total funds allocated for bad debt and charity care allowances for certified home health agencies pursuant to paragraph (b) of this subdivision to the total statewide nominal payment amounts for all eligible certified home health agencies determined in accordance with paragraph (d) of this subdivision applied to the nominal payment amount for each such certified home health agency.

(f) The bad debt and charity care allowance for each eligible public certified home health agency shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for public certified home health agencies pursuant to paragraph (b) of this subdivision to the total statewide nominal payment amounts for all eligible public certified home health agencies determined in accordance with paragraph (d) of this subdivision applied to the nominal payment amount for each such certified home health agency.

(g) Certified home health agencies shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of bad debt and charity care provided. The state hospital review and planning council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable certified home health agencies to fairly and accurately determine and report the costs of bad debt and charity care. In order to be eligible for an allowance pursuant to this subdivision, a certified home health agency must be in compliance with bad debt and charity care reporting requirements.

(h) Community service plans. (i) The governing body of a certified home health agency shall issue an organizational mission statement identifying at a minimum the populations and communities served by the agency and the agency's commitment to meeting the home care needs of the community. The commissioner shall take into consideration the limitations of agency size and resources, and allow flexibility in complying with the provisions of this section.

(ii) The governing body of the certified home health agency shall at least once every three years:

- (A) review and amend as necessary the agency's mission statement;
- (B) solicit the views of the communities served by the agency on such

issues as the agency's performance and service priorities;

(C) demonstrate the agency's operational and financial commitment to meeting community home care needs, to provide charity care service and to improve access to home care services by the underserved; and

(D) prepare and make available to the public a statement showing the provision of free, reduced charge and/or other services of a charitable or community nature.

(iii) The governing body of the certified home health agency shall annually make available to the public a review of the agency's performance in meeting the home care needs of the community, providing charity care services, and improving access to home care services by the underserved.

(iv) The governing body of the certified home health agency shall file with the commissioner its mission statement, its annual performance review, and at least every three years a report detailing amendments to the statement reflecting changes in the agency's operational and financial commitment to meeting the home care needs of the community, providing charity care services, and improving access to home care services by the underserved.

(v) The commissioner shall promulgate regulations establishing a revised percentage for the charity care requirement.

(i) This subdivision shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowances determined in accordance with this subdivision.

* NB Expires June 30, 2029

6. (a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided and real property capital construction costs

associated with the construction of a free-standing assisted living program such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, based upon the mean prices for the first of July, nineteen hundred ninety-two (utilizing nineteen hundred eighty-three costs) for freestanding, low intensity residential health care facilities with less than three hundred beds, and for years subsequent to nineteen hundred ninety-two, adjusted for inflation in accordance with the provisions of subdivision ten of section twenty-eight hundred seven-c of this chapter, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision. The commissioner shall also promulgate regulations, and may promulgate emergency regulations, to provide for reimbursement of the cost of preadmission assessments conducted directly by assisted living programs.

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: the facility houses exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-l of the social services law or (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved beds are provided to residents who are subject to the assisted living program; and (iii) the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, provided that the commissioner may adopt rules and regulations which establish a cap on

real property capital construction costs for those facilities that house exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-1 of the social services law.

(c) The department shall conduct a study of the use of resident data collected from a uniform assessment tool identified by the commissioner with respect to its effectiveness in evaluation and adjusting rates of payment for assisted living programs. On or before July thirty-first, two thousand eleven, the commissioner shall provide the governor, the speaker of the assembly, the temporary president of the senate, and the chairpersons of the assembly and senate health committees with a report setting forth the conclusions of such study.

7. * Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and for rate periods beginning on or after January first, nineteen hundred ninety-six, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. The amount of such reduction in certified home health agency rates of payments made during the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be adjusted in the nineteen hundred ninety-six rate period on a pro-rata basis, if it is determined upon post-audit review by June fifteenth, nineteen hundred ninety-six and reconciliation that the savings for the state share, excluding the federal and local government shares, of medical assistance payments pursuant to title eleven of article five of the social services law based on the limitation of such payment pursuant to this subdivision is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March thirty-first, nineteen hundred ninety-six to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. For rate periods on and after January first, two thousand five through December thirty-first, two thousand

six, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

* NB Effective until March 31, 2029

* Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for certified home health agencies and long term home health care programs for rate period beginning on or after January first, nineteen hundred ninety-five, the department of health may not by rule or regulation limit the reimbursable base year administrative and general costs of a provider of services to a percentage which is other than thirty percent of total reimbursable base year operational costs of such provider of services.

* NB Effective March 31, 2029

No such limit shall be applied to a provider of services reimbursed on an initial budget basis, or a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as a base year in determining rates of payment.

For the purposes of this subdivision, reimbursable base year operational costs shall mean those base year operational costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines.

The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction for the rate promulgated by the commissioner to each certified home health agency and long term home health care program provider.

7-a. Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and

after April first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen and on and after April first, two thousand thirteen through March thirty-first, two thousand fifteen, and on and after April 1st, two thousand fifteen through March thirty-first, two thousand seventeen the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

No such limit shall be applied to a provider of services reimbursed on an initial budget basis, or a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as a base year in determining rates of payment.

For the purposes of this subdivision, reimbursable base year operational costs shall mean those base year operational costs remaining after application of all other efficiency standards, including, but not limited to, cost guidelines.

The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction for the rate promulgated by the commissioner to each long term home health care program provider.

8. (a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs and AIDS home care programs in accordance with this paragraph and paragraph (b) of this subdivision for purposes of improving recruitment and retention of non-supervisory home care

services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

(i) rates of payment by governmental agencies for certified home health agency services for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department (including services provided through contracts with licensed home care services agencies) shall be increased by three percent;

(ii) rates of payment by governmental agencies for long term home health care program services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent; and

(iii) rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

(b) (i) Providers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Such purposes shall include the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed in licensed home care services agencies under contract with such providers. Providers are prohibited from using such funds for any other purpose.

(ii) Each such provider shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Such recoupment shall be in

addition to any other penalties provided by law.

(iii) In the case of services provided by such providers through contracts with licensed home care services agencies, rate increases received by such providers pursuant to this subdivision shall be reflected, consistent with the purposes of subparagraph (i) of this paragraph, in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this subdivision. Such recoupment will be in addition to any other penalties provided by law.

(iv) Funds under this subdivision are not intended to supplant support provided by local government.

9. Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment for certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs, AIDS home care programs established pursuant to this article, hospice programs established under article forty of this chapter and for managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or

other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

(a) for the period June first, two thousand six through December thirty-first, two thousand six, fifty million dollars;

(b) for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty million dollars;

(c) for the period July first, two thousand seven through March thirty-first, two thousand eight, up to one hundred million dollars;

(d) for the period April first, two thousand eight through March thirty-first, two thousand nine, up to one hundred million dollars;

(e) for the period April first, two thousand nine through March thirty-first, two thousand ten, up to one hundred million dollars;

(f) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to one hundred million dollars;

(g) for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to one hundred million dollars;

(h) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to one hundred million dollars;

(i) for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, up to one hundred million dollars;

(j) for the period April first, two thousand fourteen through March thirty-first, two thousand fifteen, up to one hundred million dollars;

(k) for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, up to one hundred million dollars;

(l) for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, up to one hundred million dollars;

(m) for the period April first, two thousand seventeen through March thirty-first, two thousand eighteen, up to one hundred million dollars;

(n) for the period April first, two thousand eighteen through March thirty-first, two thousand nineteen, up to one hundred million dollars;

(o) for the period April first, two thousand nineteen through March thirty-first, two thousand twenty, up to one hundred million dollars;

(p) for the period April first, two thousand twenty through March thirty-first, two thousand twenty-one, up to one hundred million dollars;

(q) for the period April first, two thousand twenty-one through March thirty-first, two thousand twenty-two, up to one hundred million

dollars;

(r) for the period April first, two thousand twenty-two through March thirty-first, two thousand twenty-three, up to one hundred million dollars;

(s) for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-four, up to one hundred million dollars;

(t) for the period April first, two thousand twenty-four through March thirty-first, two thousand twenty-five, up to one hundred million dollars;

(u) for the period April first, two thousand twenty-five through March thirty-first, two thousand twenty-six, up to one hundred million dollars;

(v) for the period April first, two thousand twenty-six through March thirty-first, two thousand twenty-seven, up to one hundred million dollars;

(w) for the period April first, two thousand twenty-seven through March thirty-first, two thousand twenty-eight, up to one hundred million dollars;

(x) for the period April first, two thousand twenty-eight through March thirty-first, two thousand twenty-nine, up to one hundred million dollars.

10. (a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health agency, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; provided that such adjustments to rates of payments to certified home health agencies shall only be for that portion of services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA

operating under a pilot program approved by the department.

(b) Programs which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment, training and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Such purpose shall include the recruitment, training and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed in licensed home care services agencies under contract with such agencies. Such agencies are prohibited from using such fund for any other purpose. For purposes of the long term home health care program, such payment shall be treated as supplemental payments and not effect any current cost cap requirement. Each such agency shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. The commissioner is authorized to audit each such agency or program to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(c) In the case of services provided by such agencies or programs through contracts with licensed home care services agencies, rate increases received by such agencies or programs pursuant to this subdivision shall be reflected, consistent with the purposes of this subdivision, in either the fees paid or benefits or other supports, including training, provided to non-supervisory home health aides or any other personnel with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports shall be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies or programs shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment, training and retention of non-supervisory home health aides or other personnel with direct patient care responsibility

and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The commissioner is authorized to audit such agencies or programs to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this subdivision. Such recoupment shall be in addition to any other penalties provided by law.

(d) Funds under this subdivision are not intended to supplant support provided by local government.

11. (a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the availability of federal financial participation, the commissioner is authorized and directed to implement a program whereby he or she shall adjust medical assistance rates of payment for services provided by certified home health agencies, long term home health care programs, AIDS home care programs and providers of personal care services and/or providers of private duty nursing services under the social services law in accordance with this subdivision for purposes of enhancing the provision, accessibility, quality and/or efficiency of home care services. Such rate adjustments shall be for the purposes of assisting such providers, located in social services districts which do not include a city with a population of over one million persons, in meeting the cost of:

(i) Increased use of technology in the delivery of services, including telehealth and clinical and administrative management information system;

(ii) Specialty training of direct service personnel in dementia care, pediatric care and/or the care of other conditions or populations with complex needs;

(iii) Increased auto and travel expenses associated with rising fuel prices, including the increased cost of providing services in remote areas; and/or

(iv) Providing enhanced access to care for high need populations;

(v) Such other purposes related to the provision of quality, accessible home care services as the commissioner may deem appropriate.

(b) The commissioner shall increase the medical assistance rates of payment pursuant to this subdivision in an amount up to an aggregate of

sixteen million dollars for the period June first, two thousand six through March thirty-first, two thousand seven, and sixteen million dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, and sixteen million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, provided however that if federal financial participation is not available for rate adjustments pursuant to this subdivision such aggregate amount shall not exceed eight million dollars, and provided, further, however, that for purposes of long term home health care programs, such payments provided pursuant to this subdivision shall be treated as supplemental payments and shall not effect any current cost cap requirement.

(c) Such rate adjustments shall be in the form of a uniform percentage add-on to the rates, as determined by the department, based on the proportion of the total allocated adjustment dollars, as determined in paragraph (b) of this subdivision, to the total medicaid expenditures for services provided for certified home health agencies, long-term home health care programs, AIDS nursing, personal care assistants and private duty nurses services in local social services districts which do not include a city with a population over one million.

12. (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective on and after April first, two thousand eleven through March thirty-first, two thousand twelve, rates of payment by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the commissioner pursuant to regulations, shall reflect ceiling limitations determined in accordance with this subdivision, provided, however, that at the discretion of the commissioner such ceilings may, as an alternative, be applied to payments for services provided on and after April first, two thousand eleven, except for such services provided to children and other discrete groups as may be determined by the commissioner pursuant to regulations. In determining such payments or rates of payment, agency ceilings shall be established. Such ceilings shall be applied to payments or rates of payment for certified home

health agency services as established pursuant to this section and applicable regulations. Ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the commissioner. Such ceilings will be effective April first, two thousand eleven through March thirty-first, two thousand twelve. An interim payment or rate of payment adjustment effective April first, two thousand eleven, shall be applied to agencies with projected average per patient Medicaid claims, as determined by the commissioner, to be over their ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

(b) Ceiling limitations determined pursuant to paragraph (a) of this subdivision shall be subject to reconciliation. In determining payment or rate of payment adjustments based on such reconciliation, adjusted agency ceilings shall be established. Such adjusted ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the two thousand nine calendar year to the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner. Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April first, two thousand eleven through March thirty-first, two thousand twelve. In those instances when an agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the state and may be recouped by the department in a lump sum amount or through reductions in the Medicaid payments due to the agency. In those instances where an interim payment or rate of payment adjustment was applied to an agency

in accordance with paragraph (a) of this subdivision, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

(c) Interim payment or rate of payment adjustments pursuant to this subdivision shall be based on Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year two thousand nine. Amounts due from reconciling rate adjustments shall be based on Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year two thousand nine and Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the reconciliation period April first, two thousand eleven through March thirty-first, two thousand twelve. In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(d) The commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision. The commissioner may promulgate regulations to implement the provisions of this subdivision.

(e) Payments or rate of payment adjustments determined pursuant to this subdivision shall, for the period April first, two thousand eleven through March thirty-first, two thousand twelve, be retroactively reconciled utilizing the methodology in paragraph (b) of this subdivision and utilizing actual paid claims from such period.

(f) Notwithstanding any inconsistent provision of this subdivision, payments or rate of payment adjustments made pursuant to this subdivision shall not result in an aggregate annual decrease in Medicaid payments to providers subject to this subdivision that is in excess of two hundred million dollars, as determined by the commissioner and not subject to subsequent adjustment, and the commissioner shall make such adjustments to such payments or rates of payment as are necessary to ensure that such aggregate limits on payment decreases are not exceeded.

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

(b) Initial base year episodic payments shall be based on Medicaid paid claims, as determined and adjusted by the commissioner to achieve savings comparable to the prior state fiscal year, for services provided by all certified home health agencies in the base year two thousand nine. Subsequent base year episodic payments may be based on Medicaid paid claims for services provided by all certified home health agencies in a base year subsequent to two thousand nine, as determined by the commissioner, provided, however, that such base year adjustment shall be made not less frequently than every three years. In determining case mix, each patient shall be classified using a system based on measures which may include, but not limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(c) The commissioner may require agencies to collect and submit any data required to implement this subdivision. The commissioner may promulgate regulations to implement the provisions of this subdivision.

14. (a) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after March first, two thousand fourteen the commissioner shall adjust Medicaid rates of payment for services provided by certified home health agencies to address cost increases stemming from the wage increases required by implementation of the provisions of section thirty-six

hundred fourteen-c of this article. Such rate adjustments shall be based on a comparison, as determined by the commissioner, of the hourly compensation levels for home health aides and personal care aides as reflected in the existing Medicaid rates for certified home health agencies to the hourly compensation levels incurred as a result of complying with the provisions of section thirty-six hundred fourteen-c of this article.

(b) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after March first, two thousand fourteen the commissioner shall adjust Medicaid rates of payment for services provided by long term home health care programs to address cost increases stemming from the wage increases required by implementation of the provisions of section thirty-six hundred fourteen-c of this article. Such rate adjustments shall be based on a comparison, as determined by the commissioner, of the hourly compensation levels for home health aides and personal care aides as reflected in the existing Medicaid rates for long term home health care programs to the hourly compensation levels incurred as a result of complying with the provisions of section thirty-six hundred fourteen-c of this article.

§ 3614-a. Home care provider assessments. 1. Certified home health agencies and providers of long term home health care programs are charged assessments on their gross receipts received from all patient care services and other operating income on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted by or on behalf of certified home health agencies or providers of long term home health care programs to the commissioner or his designee.

2. (a) (i) For certified home health agencies the assessment shall be six-tenths of one percent of each certified home health agency's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one for home care services; provided, however, that for all such gross receipts received on or after April first, nineteen hundred

ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(ii) For certified home health agencies there shall be an additional assessment which shall be three-tenths of one percent of each certified home health agency's gross receipts received from all patient care services and other operating income on a cash basis. The assessment year shall be April first, nineteen hundred ninety-two to March thirty-first, nineteen hundred ninety-three. The agencies shall file the assessment return with any balance due or any refund claimed by May first, nineteen hundred ninety-three. The agencies shall make estimated payments on a monthly basis starting August fifteenth, nineteen hundred ninety-two and continuing on the fifteenth of each month through March fifteenth, nineteen hundred ninety-three. Each estimated payment shall equal one-eighth of the total estimated for the assessment year. If the total of estimated payments is less than ninety-five percent of the actual payment due, the agency shall pay a penalty of fifteen percent of the difference due for each month in addition to the amount due.

(iii) For certified home health agencies, an additional assessment shall be three-tenths of one percent of each certified home health agency's gross receipts received from all patient care services and other operating income on a cash basis during the period April first, nineteen hundred ninety-three through June thirtieth, nineteen hundred ninety-four for home care services.

(b) (i) For providers of long term home health care programs the assessment shall be six-tenths of one percent of each provider's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one for long term home health care services; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(ii) For providers of long term home health programs there shall be an additional assessment which shall be three-tenths of one percent of each

provider of long term home health care's gross receipts received from all patient care services and other operating income on a cash basis. The assessment year shall be April first, nineteen hundred ninety-two to March thirty-first, nineteen hundred ninety-three. The providers shall file the assessment return with any balance due or any refund claimed by May first, nineteen hundred ninety-three. The providers shall make estimated payments on a monthly basis starting August fifteenth, nineteen hundred ninety-two and continuing on the fifteenth of each month through March fifteenth, nineteen hundred ninety-three. Each estimated payment shall equal one-eighth of the total estimated for the assessment year. If the total of estimated payments is less than ninety-five percent of the actual payment due, the provider shall pay a penalty of fifteen percent of the difference due for each month in addition to the amount due.

(iii) For providers of long term home health care programs, an additional assessment shall be three tenths of one percent of each provider's gross receipts received from all patient care services and other operating income on a cash basis during the period April first, nineteen hundred ninety-three through June thirtieth nineteenth hundred ninety-four for long term home health care services.

(c) Notwithstanding any contrary provisions of this section or any other contrary provision of law or regulation, for certified home health agencies and for providers of long term home health care programs the assessment shall be thirty-five hundredths of one percent of each agency's or provider's gross receipts received from all home health care services and other operating income on a cash basis for periods on and after April first, two thousand nine.

3. Gross receipts received from all patient care services and other operating income for purposes of the assessments pursuant to this section shall include, but not be limited to:

(a) for certified home health agencies, all monies received for or on account of home care services, including personal care services, excluding subject to the provisions of subdivision twelve of this section the component of rates of payment related to the allowance provided in accordance with subdivision five of section thirty-six hundred fourteen of this article;

(b) for providers of long term home health care programs, all monies received for or on account of long term home health care services, including personal care services;

(c) provided, however, that subject to the provisions of subdivision twelve of this section income received from grants, charitable contributions, donations and bequests and governmental deficit financing shall not be included.

4. The commissioner is authorized to contract with the article forty-three insurance law plans, or such other administrators as the commissioner shall designate, to receive and distribute home care provider assessment funds and personal care services provider assessment funds assessed pursuant to section three hundred sixty-seven-i of the social services law. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the assessment funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars for all assessments established pursuant to this section and the personal care services provider assessment established pursuant to section three hundred sixty-seven-i of the social services law, shall be paid from the assessment funds.

5. Estimated payments by or on behalf of certified home health agencies and providers of long term home health care programs to the commissioner or his designee of funds due from the assessments pursuant to subdivision two of this section shall be made on a monthly basis. Estimated payments shall be due on or before the fifteenth day following the end of a calendar month to which an assessment applies.

6. (a) If an estimated payment made for a month to which an assessment applies is less than seventy percent of an amount the commissioner determines is due, based on evidence of prior period moneys received by a certified home health agency or provider of a long term home health care program or evidence of moneys received by such entity for that month, the commissioner may estimate the amount due from such entity and

may collect the deficiency pursuant to paragraph (c) of this subdivision.

(b) If an estimated payment made for a month to which an assessment applies is less than ninety percent of an amount the commissioner determines is due, based on evidence of prior period moneys received by a certified home health agency or provider of a long term home health care program or evidence of moneys received by such certified home health agency or provider of a long term home health care program for that month, and at least two previous estimated payments within the preceding six months were less than ninety percent of the amount due, based on similar evidence, the commissioner may estimate the amount due from such entity and may collect the deficiency pursuant to paragraph (c) of this subdivision.

(c) Upon receipt of notification from the commissioner of an entity's deficiency under this section, the comptroller or a fiscal intermediary designated by the director of the budget, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law, or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or by such article forty-three corporation or article forty-four organization to the entity the amount of the deficiency determined under paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section. Upon withholding such amount, the comptroller or a designated fiscal intermediary, or the commissioner of social services, or corporation organized and operating in accordance with article forty-three of the insurance law or organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld on behalf of the entity.

(d) The commissioner shall provide an entity with notice of any estimate of an amount due for an assessment pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section at least three days prior to collection of such amount by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(e) In the event the certified home health agency or provider of a long term home health care program objects to an estimate by the

commissioner pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section of the amount due for an assessment, the entity, within sixty days of notice of an amount due, may request a public hearing. If a hearing is requested, the commissioner shall provide the entity an opportunity to be heard and to present evidence bearing on the amount due for an assessment within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. An administrative hearing is not a prerequisite to seeking judicial relief.

(f) The commissioner may direct that a hearing be held without any request by the entity.

7. (a) Every certified home health agency or provider of a long term home health care program shall submit reports on a cash basis of actual gross receipts received from all patient care services and operating income for each month as follows:

(i) for the period January first, nineteen hundred ninety-one through January thirty-first, nineteen hundred ninety-one, the report shall be filed on or before March fifteenth, nineteen hundred ninety-one; and

(ii) for the quarter year ending March thirty-first, nineteen hundred ninety-one and for each quarter thereafter, the report shall be filed on or before the forty-fifth day after the end of such quarter.

(b) Every certified home health agency or provider of a long term home health care program shall submit a certified annual report on a cash basis of gross receipts received in such calendar year from all patient care services and operating income.

(c) The reports shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section.

(d) Final payments shall be due for all certified home health agencies or providers of long term home health care programs for assessments pursuant to subdivision two of this section upon the due date for submission of the applicable quarterly report.

(e) The commissioner may recoup deficiencies in final payments pursuant to paragraph (c) of subdivision six of this section.

8. (a) If an estimated payment made for a month to which an assessment

applies is less than ninety percent of the actual amount due for such month, interest shall be due and payable to the commissioner on the difference between the amount paid and the amount due from the day of the month the estimated payment was due until the date of payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest, if not paid by the due date of the following month's estimated payment, may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

(b) If an estimated payment made for a month to which an assessment applies is less than seventy percent of the actual amount due for such month, a penalty shall be due and payable to the commissioner of five percent of the difference between the amount paid and the amount due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

(c) Overpayment by a certified home health agency or provider of a long term home health care program of an estimated payment shall be applied to any other payment due from the entity pursuant to this section, or, if no payment is due, at the election of the entity shall be applied to future estimated payments or refunded to the entity. Interest shall be paid on overpayments from the date of overpayment to the date of crediting or refund at the rate determined in accordance with paragraph (a) of this subdivision if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

9. Funds accumulated, including income from invested funds, from the assessments specified in this section, including interest and penalties,

shall be deposited by the commissioner and credited to the general fund.

10. Notwithstanding any inconsistent provision of law or regulation to the contrary, the assessments pursuant to this section shall not be an allowable cost in the determination of reimbursement rates pursuant to this article.

11. (c) The assessment shall not be collected in excess of twenty million four hundred thousand dollars from certified home health agencies and long term home health care programs pursuant to subdivision two of this section, licensed home care services agencies pursuant to subdivision two of section thirty-six hundred fourteen-b of this article and personal care services providers pursuant to subdivision two of section three hundred sixty-seven-i of the social services law for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight. The amount of the assessment collected in excess of twenty million four hundred thousand dollars for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight shall be refunded by the commissioner based on the ratio which a certified home health agency's, long term home health care program's, licensed home care services agency's or personal care services provider's assessment for such period bears to the total of the assessments for such period paid by such providers of services.

12. Each exclusion of sources of gross receipts received from the assessments effective on or after April first, nineteen hundred ninety-two established pursuant to this section shall be contingent upon either: (a) qualification of the assessments for waiver pursuant to federal law and regulation; or (b) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the assessments relying on

such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the assessments do not so qualify based on any such exclusion, the exclusion shall be deemed to have been null and void as of April first, nineteen hundred ninety-two, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the certified home health agency or provider of a long term home health care program pays the retroactive amount due within ninety days of notice from the commissioner of health to the provider of services that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner to the provider of services.

§ 3614-b. Licensed home care services agencies assessments. 1.

Licensed home care services agencies are charged assessments, subject to the provisions of subdivision thirteen of this section, on their gross receipts received from all patient care services and other operating income on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted by or on behalf of licensed home care services agencies to the commissioner or his designee.

2. (a) The assessment shall be six-tenths of one percent of such licensed home care services agency's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-two; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(b) Notwithstanding any contrary provisions of this section or any other contrary provision of law or regulation, the assessment shall be thirty-five hundredths of one percent of each such licensed home care services agency's gross receipts received from all personal care

services and other operating income on a cash basis for periods on and after April first, two thousand nine.

3. Gross receipts received from all patient care services and other operating income for purposes of the assessment pursuant to this section shall include, but not be limited to, all moneys received for or on account of home care services provided pursuant to a license issued by the commissioner in accordance with the provisions of section thirty-six hundred five of this article, provided, however, subject to the provisions of subdivision twelve of this section that income received from grants, charitable contributions, donations and bequests and governmental deficit financing shall not be included, and further, that moneys received on which an assessment is paid by a hospital pursuant to section twenty-eight hundred seven-d of this chapter, home care provider pursuant to section thirty-six hundred fourteen-a of this article, personal care services provider pursuant to section three hundred sixty-seven-i of the social services law or provider of services pursuant to section 43.04 or 43.06 of the mental hygiene law shall not be included.

4. The commissioner is authorized to contract with the article forty-three insurance law plans, or if not available such other administrators as the commissioner shall designate, to receive and distribute licensed home care services agency assessment funds. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the assessment funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars for all assessments established pursuant to this section, shall be paid from the assessment funds.

5. Estimated payments by or on behalf of licensed home care services agencies to the commissioner or his or her designee of funds due from the assessments pursuant to subdivision two of this section shall be made on a monthly basis. Estimated payments shall be due on or before the fifteenth day following the end of the calendar month to which an

assessment applies.

6. (a) If an estimated payment made for a month to which an assessment applies is less than seventy percent of an amount the commissioner determines is due, based on evidence of prior moneys received by a licensed home care services agency or evidence of moneys received by such agency for that month, the commissioner may estimate the amount due from such agency and may collect the deficiency pursuant to paragraph (c) of this subdivision.

(b) If an estimated payment made for the month to which an assessment applies is less than ninety percent of an amount the commissioner determines is due, based on evidence of prior period moneys received by a licensed home care services agency or evidence of moneys received by such agency for that month, and at least two previous estimated payments within the preceding six months were less than ninety percent of the amount due, based on similar evidence, the commissioner may estimate the amount due from such agency and may collect the deficiency pursuant to paragraph (c) of this subdivision.

(c) Upon receipt of notification from the commissioner of a licensed home care services agency's deficiency under this section, the comptroller or a fiscal intermediary designated by the director of the budget, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law or article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or by such article forty-three corporation or article forty-four organization to the agency the amount of the deficiency determined under paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section. Upon withholding such amount, the comptroller or a designated fiscal intermediary, or the commissioner of social services, or corporation organized and operating in accordance with article forty-three of the insurance law or article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld on behalf of the licensed home care services agency.

(d) The commissioner shall provide a licensed home care services agency with notice of any estimate of an amount due for an assessment pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of

subdivision seven of this section at least three days prior to collection of such amount by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(e) In the event a licensed home care services agency objects to an estimate by the commissioner pursuant to paragraph (a) or (b) of this subdivision or paragraph (e) of subdivision seven of this section of the amount due for an assessment, the agency, within sixty days of notice of an amount due, may request a public hearing. If a hearing is requested, the commissioner shall provide the licensed home care services agency with an opportunity to be heard and to present evidence bearing on the amount due for an assessment within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. An administrative hearing is not a prerequisite to seeking judicial relief.

(f) The commissioner may direct that a hearing be held without any request by an agency.

7. (a) Every licensed home care services agency shall submit reports on a cash basis of actual gross receipts received from all patient care services and other operating income for each month as follows: for the quarter year ending June thirtieth, nineteen hundred ninety-two and for each quarter thereafter, the report shall be filed on or before the forty-fifth day after the end of such period.

(b) Every licensed home care services agency shall submit a certified annual report on a cash basis of gross receipts received in such calendar year from all patient care services and other operating income.

(c) The reports shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section.

(d) Final payments shall be due for all licensed home care services agencies for the assessments pursuant to subdivision two of this section upon the due date for submission of the applicable quarterly report.

(e) The commissioner may recoup deficiencies in final payments pursuant to paragraph (c) of subdivision six of this section.

8. (a) If an estimated payment made for a month to which assessment applies is less than ninety percent of the actual amount due for such month, interest shall be due and payable to the commissioner on the

difference between the amount paid and the amount due from the day of the month the estimated payment was due until the date of the payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayment of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest, if not paid by the due date of the following month's estimated payment, may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

(b) If an estimated payment for such month to which an assessment applies is less than seventy percent of the actual amount due for such month, a penalty shall be due and payable to the commissioner of five percent of the difference between the amount paid and the amount due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an assessment pursuant to subdivision two of this section.

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

9. Funds accumulated, including income from invested funds, from the assessments specified in this section, including interest and penalties, shall be deposited by the commissioner and credited to the general fund.

10. Notwithstanding any inconsistent provision of law or regulation to the contrary, the assessments pursuant to this section shall not be an allowable cost in the determination of reimbursement rates or fees pursuant to this chapter or the social services law.

11. The aggregate limit on the assessment for certified home health agencies, long term home health care programs, licensed home care services agencies and personal care services providers established pursuant to paragraph (c) of subdivision eleven of section thirty-six hundred fourteen-a of this article for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight shall be deemed to reflect the amount of one million three hundred thousand dollars for the assessment pursuant to subdivision two of this section for such period. In the event, in accordance with subdivision thirteen of this section, the assessments pursuant to subdivision two of this section are not implemented, such aggregate limit shall be reduced by one million three hundred thousand dollars for the period of April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight.

12. Each exclusion of sources of gross receipts received from the assessments effective on or after April first, nineteen hundred ninety-two established pursuant to this section shall be contingent upon either: (a) qualification of the assessments for waiver pursuant to federal law and regulation; or (b) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the assessments relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event that the secretary of the department of health and human services determines that the assessments do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of April first,

nineteen hundred ninety-two, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the licensed home care services agency pays the retroactive amount due within ninety days of notice from the commissioner to the agency that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner to the agency.

13. This section shall be of no force and effect upon either: (a) a waiver is granted pursuant to federal law and regulation; or (b) consistent with federal law and regulation, a waiver is not required by the secretary of the department of health and human services for the exclusion of the home care services agencies assessed pursuant to this section from such assessment; in order for the assessments pursuant to section thirty-six hundred fourteen-a of this article and section three hundred sixty-seven-i of the social services law to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to section thirty-six hundred fourteen-a of this article and section three hundred sixty-seven-i of the social services law not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall not collect the assessments under this section, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the assessments pursuant to section thirty-six hundred fourteen-a of this chapter or section three hundred sixty-seven-i of the social services law do not so qualify based on the exclusion of licensed home care services agencies from assessments, then the exclusion shall be deemed to have been null and void as of April first, nineteen hundred ninety-two, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the licensed home care services agency pays the retroactive amount due within ninety days of notice from the commissioner to the agency that the exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner to the agency.

§ 3614-c. Home care worker wage parity. 1. As used in this section, the following terms shall have the following meaning:

(a) "Living wage law" means any law enacted by Nassau, Suffolk or Westchester county or a city with a population of one million or more which establishes a minimum wage for some or all employees who perform work on contracts with such county or city.

(b) "Total compensation" means all wages and other direct compensation paid to or provided on behalf of the employee including, but not limited to, wages, health, education or pension benefits, supplements in lieu of benefits and compensated time off, except that it does not include employer taxes or employer portion of payments for statutory benefits, including but not limited to FICA, disability insurance, unemployment insurance and workers' compensation.

(c) "Prevailing rate of total compensation" means the average hourly amount of total compensation paid to all home care aides covered by whatever collectively bargained agreement covers the greatest number of home care aides in a city with a population of one million or more. For purposes of this definition, any set of collectively bargained agreements in such city with substantially the same terms and conditions relating to total compensation shall be considered as a single collectively bargained agreement.

(d) "Home care aide" means a home health aide, personal care aide, home attendant, personal assistant performing consumer directed personal assistance services pursuant to section three hundred sixty-five-f of the social services law, or other licensed or unlicensed person whose primary responsibility includes the provision of in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks; provided, however, that home care aide does not include any individual (i) working on a casual basis, or (ii) (except for a person employed under the consumer directed personal assistance program under section three hundred sixty-five-f of the social services law) who is a relative through blood, marriage or adoption of: (1) the employer; or (2) the person for whom the worker is delivering services, under a program funded or administered by federal, state or local government.

(e) "Managed care plan" means any managed care program, organization

or demonstration covering personal care or home health aide services, and which receives premiums funded, in whole or in part, by the New York state medical assistance program, including but not limited to all Medicaid managed care, Medicaid managed long term care, Medicaid advantage, and Medicaid advantage plus plans and all programs of all-inclusive care for the elderly.

(f) "Episode of care" means any service unit reimbursed, in whole or in part, by the New York state medical assistance program, whether through direct reimbursement or covered by a premium payment, and which covers, in whole or in part, any service provided by a home care aide, including but not limited to all service units defined as visits, hours, days, months or episodes.

(g) "Cash portion of the minimum rate of home care aide total compensation" means the minimum amount of home care aide total compensation that may be paid in cash wages, as determined by the department in consultation with the department of labor.

(h) "Benefit portion of the minimum rate of home care aide total compensation" means the portion of home care aide total compensation that may be paid in cash or health, education or pension benefits, wage differentials, supplements in lieu of benefits and compensated time off, as determined by the department in consultation with the department of labor. Cash wages paid pursuant to increases in the state or federal minimum wage cannot be used to satisfy the benefit portion of the minimum rate of home care aide total compensation.

(i) "Fiscal intermediary" means a fiscal intermediary in the consumer directed personal assistance program under section three hundred sixty-five-f of the social services law.

2. Notwithstanding any inconsistent provision of law, rule or regulation, no payments by government agencies shall be made to certified home health agencies, long term home health care programs, managed care plans, fiscal intermediaries, the nursing home transition and diversion waiver program under section three hundred sixty-six of the social services law, or the traumatic brain injury waiver program under section twenty-seven hundred forty of this chapter for any episode of care furnished, in whole or in part, by any home care aide who is compensated at amounts less than the applicable minimum rate of home

care aide total compensation established pursuant to this section.

3. (a) The minimum rate of home care aide total compensation in a city with a population of one million or more shall be:

(i) for the period March first, two thousand twelve through February twenty-eighth, two thousand thirteen, ninety percent of the total compensation mandated by the living wage law of such city;

(ii) for the period March first, two thousand thirteen through February twenty-eighth, two thousand fourteen, ninety-five percent of the total compensation mandated by the living wage law of such city;

(iii) for the period March first, two thousand fourteen through March thirty-first two thousand sixteen, no less than the prevailing rate of total compensation as of January first, two thousand eleven, or the total compensation mandated by the living wage law of such city, whichever is greater;

(iv) for the period April first, two thousand sixteen, through December thirty-first, two thousand twenty-two the cash portion of the minimum rate of home care aide total compensation shall be ten dollars or the minimum wage as laid out in paragraph (a) of subdivision one of section six hundred fifty-two of the labor law, whichever is higher. The benefit portion of the minimum rate of home care aide total compensation shall be four dollars and nine cents;

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

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

(b) The minimum rate of home care aide total compensation in the counties of Nassau, Suffolk and Westchester shall be:

(i) for the period March first, two thousand thirteen through February twenty-eighth, two thousand fourteen, ninety percent of the total compensation mandated by the living wage law as set on March first, two thousand thirteen of a city with a population of a million or more;

(ii) for the period March first, two thousand fourteen through February twenty-eighth, two thousand fifteen, ninety-five percent of the total compensation mandated by the living wage law as set on March first, two thousand fourteen of a city with a population of a million or more;

(iii) for the period March first, two thousand fifteen, through February twenty-eighth, two thousand sixteen, one hundred percent of the total compensation mandated by the living wage law as set on March first, two thousand fifteen of a city with a population of a million or more;

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

(v) for the period January first, two thousand twenty-three through December thirty-first, two thousand twenty-three, the cash portion of the minimum rate of home care aide total compensation shall be the minimum wage for the applicable region, as defined in section thirty-six hundred fourteen-f of this article. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and twenty-two cents;

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

4. The terms of this section shall apply equally to services provided by home care aides who work on episodes of care as direct employees of

certified home health agencies, long term home health care programs, or managed care plans, or as employees of licensed home care services agencies, limited licensed home care services agencies, or fiscal intermediaries, or under any other arrangement.

5. No payments by government agencies shall be made to certified home health agencies, licensed home care services agencies, long term home health care programs, managed care plans, fiscal intermediaries for any episode of care without the certified home health agency, licensed home care services agency, long term home health care program, managed care plan or the fiscal intermediary, having delivered prior written certification to the commissioner annually, at a time prescribed by the commissioner, on forms prepared by the department in consultation with the department of labor, that all services provided under each episode of care during the period covered by the certification are in full compliance with the terms of this section and any regulations promulgated pursuant to this section and that no portion of the dollars spent or to be spent to satisfy the wage or benefit portion under this section shall be returned to the certified home health agency, licensed home care services agency, long term home health care program, managed care plan, or fiscal intermediary, related persons or entities, other than to a home care aide as defined in this section to whom the wage or benefits are due, as a refund, dividend, profit, or in any other manner. Such written certification shall also verify that the certified home health agency, long term home health care program, or managed care plan has received from the licensed home care services agency, fiscal intermediary, or other third party an annual statement of wage parity hours and expenses on a form provided by the department of labor accompanied by an independently-audited financial statement verifying such expenses.

5-a. No portion of the dollars spent or to be spent to satisfy the wage or benefit portion under this section shall be returned to the certified home health agency, licensed home care services agency, long term home health care program, managed care plan, or fiscal intermediary, related persons or entities, other than to a home care aide as defined in this section to whom the wage or benefits are due, as

a refund, dividend, profit, or in any other manner.

6. If a certified home health agency, long term home health care program or managed care plan elects to provide home care aide services through contracts with licensed home care services agencies, fiscal intermediaries, or through other third parties, provided that the episode of care on which the home care aide works is covered under the terms of this section, the certified home health agency, long term home health care program, or managed care plan shall include in its contracts, a requirement that it be provided with a written certification, verified by oath, from the licensed home care services agency, fiscal intermediary, or other third party, on forms prepared by the department in consultation with the department of labor, which attests to the licensed home care services agency's, fiscal intermediary's, or other third party's compliance with the terms of this section. Such contracts shall also obligate the licensed home care services agency, fiscal intermediary, or other third party to provide the certified home health agency, long term home health care program, or managed care plan all information from the licensed home care services agency, fiscal intermediary or other third party necessary to verify compliance with the terms of this section, which shall include an annual compliance statement of wage parity hours and expenses on a form provided by the department of labor accompanied by an independently-audited financial statement verifying such expenses. Such annual statements shall be available no less than annually for the previous calendar year, at a time as prescribed by the commissioner. Such certifications, the information necessary to verify compliance, and the annual compliance statement and financial statements shall be retained by all certified home health agencies, long term home health care programs, or managed care plans, and all licensed home care services agencies, fiscal intermediaries, or other third parties for a period of no less than ten years, and made available to the department upon request. Any licensed home care services agency, fiscal intermediary, or other third party who shall upon oath verify any statement required to be transmitted under this section and any regulations promulgated pursuant to this section which is known by such party to be false shall be guilty of perjury and punishable as provided

by the penal law.

6-a. The certified home health agency, long term home health care program, or managed care plan shall review and assess the annual compliance statement of wage parity hours and expenses and make a written referral to the department of labor for any reasonably suspected failures of licensed home care services agencies, fiscal intermediaries, or third parties to conform to the wage parity requirements of this section.

7. The commissioner shall distribute to all certified home health agencies, long term home health care programs, managed care plans, licensed home care services agencies, and fiscal intermediaries official notice of the minimum rates of home care aide compensation at least one hundred twenty days prior to the effective date of each minimum rate for each social services district covered by the terms of this section.

7-a. Any certified home health agency, licensed home care services agency, long term home health care program, managed care plan, or fiscal intermediary, or other third party that willfully pays less than such stipulated minimums regarding wages and supplements, as established in this section, shall be guilty of a misdemeanor and upon conviction shall be punished, for a first offense by a fine of five hundred dollars or by imprisonment for not more than thirty days, or by both fine and imprisonment; for a second offense by a fine of one thousand dollars, and in addition thereto the contract on which the violation has occurred shall be forfeited; and no such person or corporation shall be entitled to receive any sum nor shall any officer, agent or employee of the state pay the same or authorize its payment from the funds under his or her charge or control to any person or corporation for work done upon any contract, on which the certified home health agency, licensed home care services agency, long term home health care program, managed care plan, or fiscal intermediary, or other third party has been convicted of a second offense in violation of the provisions of this section.

8. The commissioner is authorized to promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this

section.

9. Nothing in this section should be construed as applicable to any service provided by certified home health agencies, licensed home care services agencies, long term home health care programs, managed care plans, or fiscal intermediaries except for all episodes of care reimbursed in whole or in part by the New York Medicaid program.

10. No certified home health agency, managed care plan, or long term home health care program shall be liable for recoupment of payments or any other penalty under this section for services provided through a licensed home care services agency, fiscal intermediary, or other third party with which the certified home health agency, long term home health care program, or managed care plan has a contract because the licensed agency, fiscal intermediary, or other third party failed to comply with the provisions of this section if the certified home health agency, long term home health care program, or managed care plan has reasonably and in good faith collected certifications and all information required pursuant to this section and conducts the monitoring and reporting required by this section.

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

section three hundred sixty-five-f of the social services law a code that is specific to the hourly cost of services at an overtime rate; provided, however, that this section shall not be construed to require the department to develop an overtime rate.

§ 3614-e. Electronic payment of claims. The payment of claims submitted under contracts or agreements with insurers under the medical assistance program for home and community-based long-term care services provided under this article, by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law, and by residential health care facilities operating pursuant to article twenty-eight of this chapter shall be paid via electronic funds transfer. Such insurers shall include but not be limited to Medicaid managed care plans and managed long-term care plans.

§ 3614-f. Home care minimum wage increase. 1. Definitions. For the purpose of this section:

(a) "Home care aide" shall have the same meaning as defined in section thirty-six hundred fourteen-c of this article.

(b) "Home care worker wage adjustment" shall mean a supplemental amount of wages equal to the rate of change in the average of the three most recent consecutive twelve month periods between the first of August and the thirty-first of July, each over their preceding twelve month periods published by the United States department of labor non-seasonally adjusted consumer price index for northeast region urban wage earners and clerical workers (CPI-W) or any successor index as calculated by the United States department of labor.

(c) "Downstate" shall mean all counties within New York city and the counties of Nassau, Suffolk and Westchester.

(d) "Remainder of state" shall mean all counties in the state of New York other than the counties in downstate.

2. (a) Beginning October first, two thousand twenty-two, in addition to the otherwise applicable minimum wage under section six hundred fifty-two of the labor law, or any otherwise applicable wage rule or

order under article nineteen of the labor law, the minimum wage for a home care aide shall be increased by an amount of two dollars and zero cents.

(b) for the period January first, two thousand twenty-four through December thirty-first, two thousand twenty-four, the minimum wage for a home care aide shall be as follows:

(i) for each hour worked in downstate, eighteen dollars and fifty-five cents; and

(ii) for each hour worked in remainder of state, seventeen dollars and fifty-five cents;

(c) for the period January first, two thousand twenty-five through December thirty-first, two thousand twenty-five, the minimum wage for a home care aide shall be as follows:

(i) for each hour worked in downstate, nineteen dollars and ten cents; and

(ii) for each hour worked in remainder of state, eighteen dollars and ten cents;

(d) for the period January first, two thousand twenty-six through December thirty-first, two thousand twenty-six, the minimum wage for a home care aide shall be as follows:

(i) for each hour worked in downstate, nineteen dollars and sixty-five cents; and

(ii) for each hour worked in remainder of state, eighteen dollars and sixty-five cents;

(e) beginning January first, two thousand twenty-seven, and each January first thereafter, the minimum wage for a home care aide shall be the sum of the minimum wage for a home care aide from the prior calendar year and the home care worker wage adjustment.

(f) (i) Notwithstanding any provision of law to the contrary, in no event shall the minimum wage for a home care aide in downstate exceed the sum of the wage set by the commissioner of labor pursuant to paragraph (a) of subdivision one-b of section six hundred fifty-two of the labor law plus three dollars and zero cents.

(ii) Notwithstanding any provision of law to the contrary, in no event shall the minimum wage for a home care aide in remainder of state exceed the sum of the wage set by the commissioner of labor pursuant to paragraph (b) of subdivision one-b of section six hundred fifty-two of

the labor law plus three dollars and zero cents.

3. Where any home care aide is paid less than required by subdivision two of this section, the home care aide, or the commissioner of labor acting on behalf of the home care aide, may bring a civil action under article six or nineteen of the labor law; provided that this shall not preclude the commissioner of labor from taking direct administrative enforcement action under article six of the labor law.

4. (a) The department is authorized to address, to any provider of medical assistance program items and services that is an employer of home care aides, or officers thereof, any inquiry in relation to its contracts, employment or other relationship, and wages, compensation and other benefits paid to home care aides, including individually identifiable data and payroll reports. Every entity or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the department, signed by such individual, or by such officer or officers of a corporation, as the department shall designate, and affirmed by them as true under penalty of perjury. In the event any entity or person does not provide a good faith response to an inquiry from the department pursuant to this section within a time period specified by the department of not less than fifteen business days, such entity or person shall be subject to civil penalties under section twelve of this chapter. Each day after the deadline established by the department for reply until such time that the provider submits a good faith response shall be considered a separate and subsequent violation. In accordance with the process outlined in this paragraph, employers shall provide any documents or materials in the employer's possession, custody, or control that are requested by the department as needed to support or verify the employer's reply.

(b) Any reports or other information furnished to the department under this subdivision shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner, including article six of the public officers law or department regulations in conformance therewith, except as provided in this section, pursuant to a judicial subpoena issued in a pending action or proceeding, or upon

formal written request by the department of labor, the office of attorney general, or a duly authorized public agency.

(c) The department shall no less than annually provide a report to the governor, temporary president of the senate, and speaker of the assembly summarizing the information obtained by the department under this subdivision. Such report shall not contain individually identifiable data.

*** § 3615. State aid to certified home health agencies.** 1. State aid shall be provided to certified home health agencies to assist in developing and ensuring their capacity to meet community need. Funds for such aid shall be made available each year in an amount equal to twenty-five cents per capita of the population within each health systems agency region, as established pursuant to article twenty-nine of this chapter, or two hundred thousand dollars, whichever is greater. Two million five hundred thousand dollars shall be for the state's share of payments provided pursuant to subdivision five of section thirty-six hundred fourteen of this article. The remaining amount shall be for purposes of providing grants pursuant to this section and sections thirty-six hundred seven and thirty-six hundred nine of this article.

2. For purposes of funding grants pursuant to sections thirty-six hundred seven and thirty-six hundred nine of this article and grants pursuant to this section, the commissioner shall allocate the proportion of funds among the health systems agency regions using the last preceding federal census or other census data approved by the comptroller.

3. Such annual funds allocated to each health systems agency region shall be made available for grants to applicants within each such region which are determined eligible and approved by the commissioner pursuant to the provisions of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article.

4. In order to be considered eligible for receipt of a grant pursuant to this section, a certified home health agency shall submit an

application to the department. Such application shall demonstrate, to the satisfaction of the commissioner, that the agency:

(a) received a certificate of approval pursuant to the provisions of section thirty-six hundred eight of this article at least two years prior to the date of the application and that such certificate has not been revoked or annulled subsequent to its receipt and is not limited as of the time of application;

(b) shall utilize grant funds to provide home care services to persons whose residence is in an area which, due to location, is more costly to serve, or persons whose conditions require a more intensive level of home care than typically provided in a visit;

(c) shall undertake reasonable efforts to maintain financial support from public and community contributed funding sources;

(d) shall make every reasonable effort to collect payments for services from third party insurance payers, governmental payers and self-paying patients;

(e) shall have professional assistance available on a seven day per week, twenty-four hour per day basis;

(f) shall establish a reasonable relationship between costs and charges, or establish charges at approximate cost; and

(g) has no other available financial resources to serve the populations as identified in paragraph (b) of this subdivision.

5. For the purpose of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, a grant applicant shall submit a copy of its application to the health systems agency in whose region the applicant is located.

6. For the purpose of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, each health systems agency shall convene an advisory group with representatives from, but not limited to, local departments of health, including those organized and unorganized as county and part-county health districts, social services districts, offices for the aging, certified home health agencies, and consumers of home health agency services. Such advisory group, after considering recommendations from persons involved in or knowledgeable about home care services delivered in that region, shall,

consistent with state and regional health plans, identify priority regional and local needs for the purposes identified in this section and sections thirty-six hundred seven and thirty-six hundred nine of this article. The health systems agency shall provide to the commissioner the recommendations of the advisory group regarding which grant applications meet regional and local needs, as well as the advisory group's prioritization of applications.

7. For the purposes of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, the commissioner shall approve applications for grants which meet the requirements of this section pursuant to which the application is submitted and rules and regulations adopted pursuant thereto. In approving such applications, the commissioner shall take into prime consideration the recommendations of the advisory group convened by the health systems agency in whose region the applicants are located and also take into consideration other applications submitted by the same applicant for grants submitted pursuant to such sections. The commissioner shall notify each advisory group and each applicant in writing of his approval or disapproval and, if disapproval, shall state the reasons for disapproval.

8. Grants approved for the purposes of this section may be made each year for up to a two-year period or until the costs for such services provided by virtue of receipt of the grant are included in rates of payment, whichever is sooner. Certified home health agencies which receive grants pursuant to this section may reapply for grants and may be approved if the applicant satisfies the requirements of subdivision four of this section and rules and regulations adopted pursuant to this section.

9. In the event that a public certified home health agency is approved for a grant, pursuant to this section, funds provided under the grant shall not reduce the amount of aid otherwise reimbursable to such agency pursuant to article six of this chapter.

10. The commissioner is authorized to promulgate such rules and

regulations, as are necessary to carry out the provisions of this section. Such rules and regulations may include, but not be limited to, minimum and maximum grant levels.

11. Recipients of grants shall submit to the commissioner reports on the use of grants provided under this section at such times and in such format as the commissioner may prescribe.

* NB Effective until June 30, 2029

* § 3615. State grants to certified home health agencies. 1. State grants shall be provided to certified home health agencies to assist in developing and ensuring their capacity to meet community need. Funds for such grants shall be made available each year in an amount equal to twenty-five cents per capita of the population within each health systems agency region, as established pursuant to article twenty-nine of this chapter, or two hundred thousand dollars, whichever is greater.

2. The commissioner shall allocate the proportion of funds among the health systems agency regions using the last preceding federal census or other census data approved by the comptroller.

3. Seventy-five percent of such annual funds allocated to each health systems agency region shall be made available for grants to certified home health agencies within each such region which are determined eligible and approved by the commissioner pursuant to this section. Twenty-five percent of such annual funds allocated to each health systems agency region shall be made available for grants to applicants within each such region which are determined eligible and approved by the commissioner pursuant to the provisions of sections thirty-six hundred seven and thirty-six hundred nine of this article. Notwithstanding such percentages, in the event that grants approved under either percentage category are less than the amount available pursuant to such percentage, the remaining amount shall be added to and deemed available for the purposes of the other percentage amount.

4. In order to be considered eligible for receipt of a grant pursuant to this section, a certified home health agency shall submit an application to the department. Such application shall demonstrate, to

the satisfaction of the commissioner, that the agency:

(a) received a certificate of approval pursuant to the provisions of section thirty-six hundred eight of this article at least two years prior to the date of the application and that such certificate has not been revoked or annulled subsequent to its receipt and is not limited as of the time of application;

(b) shall utilize grant funds to provide home care services to persons of low income who are not otherwise eligible for government sponsored programs or not covered by insurance, persons whose residence is in an area which, due to location, is more costly to serve, or persons whose conditions require a more intensive level of home care than typically provided in a visit;

(c) shall undertake reasonable efforts to maintain financial support from public and community contributed funding sources;

(d) shall make every reasonable effort to collect payments for services from third party insurance payers, governmental payers and self-paying patients;

(e) shall have professional assistance available on a seven day per week, twenty-four hour per day basis;

(f) shall establish a reasonable relationship between costs and charges, or establish charges at approximate cost; and

(g) has no other available financial resources to serve the populations as identified in paragraph (b) of this subdivision.

5. For the purpose of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, a grant applicant shall submit a copy of its application to the health systems agency in whose region the applicant is located.

6. For the purpose of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, each health systems agency shall convene an advisory group with representatives from, but not limited to, local departments of health, including those organized and unorganized as county and part-county health districts, social services districts, offices for the aging, certified home health agencies, and consumers of home health agency services. Such advisory group, after considering recommendations from persons involved in or

knowledgeable about home care services delivered in that region, shall, consistent with state and regional health plans, identify priority regional and local needs for the purposes identified in this section and sections thirty-six hundred seven and thirty-six hundred nine of this article. The health systems agency shall provide to the commissioner the recommendations of the advisory group regarding which grant applications meet regional and local needs, as well as the advisory group's prioritization of applications.

7. For the purposes of this section and sections thirty-six hundred seven and thirty-six hundred nine of this article, the commissioner shall approve applications for grants which meet the requirements of this section pursuant to which the application is submitted and rules and regulations adopted pursuant thereto. In approving such applications, the commissioner shall take into consideration the recommendations of the advisory group convened by the health systems agency in whose region the applicants are located and also take into consideration other applications submitted by the same applicant for grants submitted pursuant to such sections. The commissioner shall notify each applicant in writing of his approval or disapproval and, if disapproval, shall state the reasons for disapproval.

8. Grants approved for the purposes of this section may be made each year for up to a two-year period or until the costs for such services provided by virtue of receipt of the grant are included in rates of payment, whichever is sooner. Certified home health agencies which receive grants pursuant to this section may reapply for grants and may be approved if the applicant satisfies the requirements of subdivision four of this section and rules and regulations adopted pursuant to this section.

9. In the event that a public certified home health agency is approved for a grant, pursuant to this section, funds provided under the grant shall not reduce the amount of aid otherwise reimbursable to such agency pursuant to article six of this chapter.

10. The commissioner is authorized to promulgate such rules and

regulations, in consultation with the state council on home care services, as are necessary to carry out the provisions of this section. Such rules and regulations may include, but not be limited to, minimum and maximum grant levels.

11. Recipients of grants shall submit to the commissioner reports on the use of grants provided under this section at such times and in such format as the commissioner may prescribe.

* NB Effective June 30, 2029

§ 3616. Provision of certified home health agency services, long term home health care programs and AIDS home care programs. 1. A long term home health care program shall be provided only to those patients who are medically eligible for placement in a hospital or residential health care facility. An AIDS home care program shall be provided only to persons who are medically eligible for placement in a hospital or residential health care facility and who (a) are diagnosed by a physician as having acquired immune deficiency syndrome, or (b) are deemed by a physician, within his judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and whose illness, infirmity or disability can be reasonably ascertained to be associated with such infection. Provision of certified home health agency services, a long term home health care program or an AIDS home care program paid for by government funds shall be based upon, but not limited to, a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each applicant for such services or program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the applicant. In cases in which the applicant is a patient in a hospital or residential health care facility, the assessment shall be completed by persons designated by the commissioner, including, but not limited to, the applicant's physician, the discharge coordinator of the hospital or residential health care facility referring the applicant, a representative of the local department of social services, and a representative of the provider of a long term home health care program, AIDS home care program, or the

certified home health agency that will provide services for the patient. In cases in which the applicant is not a patient in a hospital or residential health care facility, the assessment shall be completed by persons designated by the commissioner including, but not limited to, the applicant's physician, a representative of the local department of social services and a representative of the provider of a long term home health care program, AIDS home care program or the certified home health agency that will provide services for the patient. The assessment shall be completed prior to or within thirty days after the provision of services begins. Payment for services provided prior to the completion of the assessment shall be made only if it is determined, based upon such assessment, that the recipient qualifies for such services. The commissioner shall prescribe the forms on which the assessment will be made.

2. Continued provision of a long term home health care program, AIDS home care program or certified home health agency services paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least every one hundred eighty days by the provider of a long term home health care program, AIDS home care program or the certified home health agency providing services for the patient and the local department of social services, and shall be reviewed by a physician charged with the responsibility by the commissioner. The commissioner shall prescribe the forms on which the assessment will be made.

3. Prior to the initial provision of services, and upon the continued provision of services pursuant to each complete reassessment, the agency shall present the recipient or the recipient's representative with a standardized written statement prepared by the department, in consultation with providers of home care services and consumer representatives, which informs the recipient or representative that the services to be provided are subject to change in accordance with a change in the recipient's needs, a change in information about the recipient's needs and/or about the formal and informal services available to meet such needs. The statement shall further inform the

recipient or representative that such notification and acknowledgement is for purposes of consumer information and education, and to establish and maintain proper understanding and expectations about the possible course of care to be provided by the agency.

§ 3616-a. Quality assurance. 1. Every certified home health agency, licensed home care services agency, long term home health care program and AIDS home care program is required to establish a quality assurance program which shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided by the agency or program.

2. Confidentiality. The information required to be collected and maintained by certified home health agencies, licensed home care services agencies, providers of long term home health care programs and AIDS home care programs pursuant to subdivision one of this section and as required by paragraphs (a) and (d) of subdivision five and subdivision six of section thirty-six hundred twelve of this chapter shall be kept confidential and shall not be released except to the department. Provided, however, that such information shall be released to a law enforcement agency upon a court order based upon probable cause that such information: (a) is relevant to a criminal investigation or proceeding and (b) cannot be obtained through any other means. Nothing in this section shall prohibit a certified home health agency, a licensed home care services agency, a long term home health care program or an AIDS home care program from voluntarily releasing what it reasonably believes to be evidence of criminality to a law enforcement agency.

3. Notwithstanding any other provision of law, none of the records, documentation or committee actions or records required to be maintained by certified home health agencies, licensed home care services agencies, providers of long term care programs or AIDS home care programs pursuant to subdivision one of this section and as required by paragraphs (a) and (d) of subdivision five and subdivision six of section thirty-six hundred twelve of this chapter shall be subject to disclosure under

article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibitions of this subdivision shall not apply to statements made by any person in attendance at such a meeting who is a party, or employee or agent of a party to any action or proceeding the subject matter of which was reviewed at such meeting. Nothing contained in this subdivision shall prohibit disclosure of records, documentation or committee actions or records relating to employment history and recommendations from being transmitted to any certified home health agency, licensed home care services agency, long-term home care program or AIDS home care program which is required by law or regulation to obtain such information.

4. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person, partnership, corporation, firm, society or other entity participating in good faith and with reasonable care in a quality assurance committee or communicating information in the possession of such person or entity, or on account of any recommendation or evaluation, regarding the qualifications, fitness, conduct or practices of any officer, director, employee or agent of such agency or program to any government agency, professional society, licensing or certification board as required by subdivision one of this section and by paragraphs (a) and (d) of subdivision five and subdivision six of section thirty-six hundred twelve of this chapter. The foregoing shall not apply to information which is untrue and communicated with malicious intent.

§ 3617. Respite projects. Certified home health agencies shall be permitted, with the prior approval of the commissioner in consultation with the director of the state office for the aging, to participate in respite projects pursuant to section two hundred eight of the elder law. The commissioner, in consultation with the director of the state office for the aging, shall promulgate rules and regulations to implement the provisions of this section.

§ 3618. Continuation of existing home health agencies. Any home health agency which, on March thirty-first, nineteen hundred seventy-eight, possessed a valid certificate of approval issued under the provisions of article twenty-eight of this chapter shall be deemed a certified home health agency and such certificate of approval shall be deemed valid under the provisions of this article.

§ 3619. Exempt agencies. Only an agency licensed pursuant to section thirty-six hundred five or certified pursuant to section thirty-six hundred eight of this chapter or exempt from the licensure requirements of section thirty-six hundred five of this chapter because the agency provides personal care or home care services exclusively to individuals pursuant to a program administered, operated or regulated by another state agency shall hold itself out or call itself a home health services agency, a home health agency or a home care services agency.

§ 3620. Authorization to provide an AIDS home care program. 1. An AIDS home care program may be provided only by a provider of a long term home health care program possessing a valid operating certificate issued under this article or an AIDS center as defined in accordance with regulations promulgated by the commissioner.

2. No agency or facility shall provide an AIDS home care program without the written authorization of the commissioner to provide such a program.

3. A provider of a long term home health care program or AIDS center seeking authorization to provide an AIDS home care program shall transmit to the commissioner an application setting forth the scope of the proposed program. Such application shall be submitted in a format and quantity determined by the commissioner. The application shall include a detailed description of the proposed program including, but not limited to, the following:

- (a) an outline of the applicant's plans for the AIDS home care program;
- (b) the need for the proposed program;
- (c) the number and types of personnel to be employed;
- (d) the ability of the applicant to provide the AIDS home care program;
- (e) the estimated number of visits to be provided;
- (f) the geographic area in which the proposed programs will be provided;
- (g) any special or unusual services, programs, or equipment to be provided;
- (h) a demonstration that the proposed program is feasible and adequate in terms of both short range and long range goals;
- (i) such other information as the commissioner may require.

The commissioner shall not approve the application unless he is satisfied as to:

- (a) the public need for the program at the time and place and under the circumstances proposed;
- (b) the financial resources of the provider of the proposed program and its sources of future revenues;
- (c) the ability of the proposed program to meet those standards established for participation as a home health agency under title XVIII of the federal Social Security Act;
- (d) the ability of the proposed program to meet the needs of AIDS patients; and
- (e) such other matters as he shall deem pertinent.

If the application is approved, the applicant shall be so notified in writing. The commissioner's written approval of the application shall constitute authorization to provide an AIDS home care program. If the commissioner proposes to disapprove the application, he shall notify the applicant in writing, stating his reasons for disapproval, and afford the applicant an opportunity for a public hearing.

4. Authorization to provide an AIDS home care program may be revoked, suspended, limited or annulled by the commissioner on proof that a

provider of an AIDS home care program has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

5. (a) Such authorization shall not be revoked, suspended, limited or annulled without a hearing. However, such authorization may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the provider of an AIDS home care program following a finding by the department that the public health or safety is in imminent danger.

(b) The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the provider of an AIDS home care program at least twenty-one days before the date fixed for the hearing. Such provider shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(c) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant.

6. (a) Notwithstanding the provisions of subdivision five of this section, the commissioner shall suspend, limit or revoke the authorization of a provider of an AIDS home care program after taking into consideration the public need for the program and the availability of other services which may serve as alternatives or substitutes, and after finding that suspending, limiting, or revoking the authorization of such provider would be within the public interest in order to conserve health resources by restricting the level of services to those which are actually needed.

(b) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular provider of an AIDS home care program, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of such provider, at least thirty days prior to making such a

finding an announcement that such a finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(c) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any provider of an AIDS home care program cause such provider and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the provider or the appropriate health systems agency may request a public hearing to be held in the county in which the provider is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(d) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

§ 3621. Payment of claims. Notwithstanding any law to the contrary, the provisions of section thirty-two hundred twenty-four-a of the insurance law, and regulations thereunder, shall apply to claims for payment submitted by a licensed home care services agency, certified home health agency, long term home health care program, or fiscal intermediary operating under section three hundred sixty-five-f of the social services law, pursuant to a contract with a payor under section forty-four hundred three-f of this chapter or section three hundred sixty-four-j of the social services law, and such claims shall be subject to and settled in compliance with the standards set forth in such section.

§ 3622. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

ARTICLE 36-A

MEDICAL EQUIPMENT SERVICE AGENCIES

- Section 3650. Definitions.
3651. Exemptions.
3652. Licensure required.
3653. Application and issuance of licenses.
3654. Powers and duties of the commissioner and department.
3655. Medical equipment service agency advisory board.
3656. Enforcement.

§ 3650. Definitions. When used in this article, the following words and phrases shall have the meanings ascribed to them in this article:

1. "Home medical equipment services" shall mean the delivery, provision, installation, maintenance and replacement of, or instruction in the use of medical equipment used by an individual requiring such services in their place of residence.

2. "Medical equipment service agency" means any person engaged in the business of providing home medical equipment services, whether directly or through a contractual arrangement, to an individual at their place of residence.

3. "Home medical equipment" shall mean technologically sophisticated medical devices which are used in a home care setting, including but not limited to:

- (a) Oxygen and oxygen delivery systems;

- (b) Ventilation and aspiration devices;
- (c) Respiratory disease management services;
- (d) Electronic and computer driven wheelchairs and seating systems;
- (e) Monitoring devices;
- (f) Transcutaneous electrical nerve simulator (tens) units;
- (g) Low air loss cutaneous pressure management devices;
- (h) Sequential compression devices;
- (i) Obstructive sleep apnea treatment devices; and
- (j) Feeding pumps.

4. "Person" shall mean an individual, corporation, partnership, joint venture, or any business entity.

5. "Board" shall mean the medical equipment service agency advisory board created by section thirty-six hundred fifty-five of this article.

§ 3651. Exemptions. The provisions of this article shall not apply to:

1. Hospitals certified pursuant to article twenty-eight of this chapter.

2. The following entities and practitioners, unless these entities or practitioners furnish home medical equipment services through a separate corporate entity, division, or other business entity:

(a) Home care service agencies, certified home health agencies, long term home health care programs, licensed home care services agencies and limited licensed home care service agencies, as defined under section thirty-six hundred two of this chapter;

(b) Exempt agencies, as defined under section thirty-six hundred nineteen of this chapter;

(c) Manufacturers and wholesale distributors of home medical equipment not engaged in direct sales to a patient;

(d) Health care practitioners authorized by law to prescribe home medical equipment, order home medical equipment, or use home medical equipment to treat their patients, including but not limited to physicians, nurses, physical therapists, respiratory therapists,

occupational therapists, speech pathologists, optometrists, chiropractors and podiatrists;

- (e) Hospice programs;
- (f) Nursing homes;
- (g) Veterinarians;
- (h) Dentists;
- (i) Emergency medical services providers; and
- (j) Pharmacists and pharmacies.

3. Any exempt person providing home medical equipment services through a third person as defined in section thirty-six hundred fifty of this article.

§ 3652. Licensure required. No medical equipment service agency located in New York state, or located in another state and providing home medical equipment services in this state may provide home medical equipment services unless a valid license has been issued as provided in this article.

§ 3653. Application and issuance of licenses. 1. An application for a license shall be made by the medical equipment service agency upon forms provided by the department. The application shall contain the name of the owner or owners, the location or locations where the medical equipment service agency is to be operated, and such other information as the department may require. The medical equipment service agency shall notify the department thirty days prior to the establishment of a new facility or location and provide a description thereof. At its discretion, the department may inspect such proposed new facility or location during this thirty day period.

2. (a) A license shall not be issued unless the commissioner determines that the medical equipment service agency complies with all applicable federal and state regulations governing the safety of home medical equipment services.

(b) An application for a license shall include the following

information:

(i) Written procedures to ensure that all personnel engaged in delivery, maintenance and repair of home medical equipment receive annual continuing education as may be required by regulation. In addition, the agency must demonstrate that the person responsible for the direct administration of the medical equipment services, is qualified by experience and training to perform such responsibilities. In addition, the agency must demonstrate that all personnel who perform services that constitute the practice of a profession defined in title eight of the education law are duly licensed or certified.

(ii) Written procedures for maintaining records of all patients receiving home medical equipment services.

(iii) Written procedures for equipment management and maintenance.

(iv) Written procedures for servicing home medical equipment based on standards prescribed by the department.

(v) A description of its quality assurance program which objectively and systematically monitors and evaluates the quality and appropriateness of care and services provided by such medical equipment service agency. The department shall deem a medical equipment service agency to be in compliance with the requirements of this subparagraph if the medical equipment services agency is accredited by a national accrediting agency approved by the department for a comparable quality assurance program.

3. A license shall be valid for three years from the date it was issued. The initial application for a permit shall be accompanied by a licensure fee of one hundred dollars.

4. The license shall specify the names of the owner or owners, and the locations from which such services may be performed. The license shall be displayed at all times in a prominent place in the medical equipment service agency's place of business.

5. Agencies located within this state shall also be required to pay a reasonable and adequate fee for its triennial inspection, which in no case shall be more than one thousand one hundred fifty dollars. Agencies located outside the state shall also be charged a reasonable and

adequate fee to cover the cost of regulations and inspecting these facilities, including a triennial inspection. Such fee shall be determined by the commissioner.

§ 3654. Powers and duties of the commissioner and department. 1. The department may conduct periodic inspections of a medical equipment service agency to determine compliance with requirements set forth in this article and any related regulations.

2. The commissioner may also require medical equipment service agencies to submit, in a form prescribed by the commissioner, semi-annual reports containing such information as is necessary to ensure compliance with the provisions of this article.

3. The department may prescribe in rules and regulations standards for the provision of home medical equipment services. To the maximum extent possible, such standards shall incorporate by reference the standards established for the provision of these services by a national accrediting agency approved by the department.

4. The department may adopt and amend rules and regulations necessary to implement this article.

§ 3655. Medical equipment service agency advisory board. 1. There is hereby created in the department a medical equipment service advisory board to consist of the commissioner or his or her designee as an ex-officio member, and eight other members appointed by the commissioner. The members shall include four representatives of the home medical equipment service industry and/or home medical equipment service providers, a rehabilitation technology specialist, a respiratory therapist, a physician, and a representative of the public. The commissioner shall designate one member to serve as chair.

2. The term of office of each member shall be for three years, provided however, that of the members first appointed, three shall be

appointed for terms which expire December thirty-first, two thousand three, two shall be appointed for terms which expire December thirty-first, two thousand four, and three shall be appointed for terms which expire December thirty-first, two thousand five. Vacancies shall be filled by appointment for the unexpired term. The members shall continue in office until the expiration of their terms and until their successors are appointed. A member may be dismissed by the commissioner for cause, or for repeated absence.

3. The board shall meet as frequently as its business shall require, in no case less than on a semi-annual basis. The members of the board shall receive no compensation for their services as members of the board, but shall be reimbursed for necessary and actual expenses incurred in the performance of his or her duties.

4. The commissioner, upon request of the board, may designate an employee of the department to assist the board in carrying out its responsibilities.

5. The board, upon an affirmative vote of a majority of its members, may make recommendations to the commissioner regarding the adoption, amendment and/or repeal of any rules, regulations, standards and policies regarding the provision of home medical equipment services.

§ 3656. Enforcement. 1. A medical equipment services agency may be subject to fines as provided by this chapter for material violations of the provisions of this article. A medical equipment services agency may have its license revoked, suspended, or limited by the commissioner for repeated violations of the requirements of this article. In such cases, the commissioner may require the agency to submit a corrective action plan for approval. The license of an agency may also be revoked, suspended or limited upon a finding that the actions of such agency have materially endangered public health and safety.

2. No permit or certificate shall be revoked, suspended, limited or annulled without an opportunity afforded the agency an administrative

hearing on the facts at issue.

ARTICLE 37

PHYSICIAN ASSISTANTS

Section 3700. Definitions.

3701. Commissioner; powers and duties.

3702. Special provisions.

3703. Statutory construction.

§ 3700. Definitions. As used in this article:

1. Physician assistant. The term "physician assistant" means a person who is licensed as a physician assistant pursuant to section sixty-five hundred forty-one of the education law.

2. Physician. The term "physician" means a practitioner of medicine licensed to practice medicine pursuant to article one hundred thirty-one of the education law.

3. Hospital. The term "hospital" means an institution or facility possessing a valid operating certificate issued pursuant to article twenty-eight of this chapter and authorized to employ physician assistants in accordance with rules and regulations of the public health and health planning council.

4. Approved program. The term "approved program" means a program for the education of physician assistants which has been formally approved by the education department.

§ 3701. Commissioner; powers and duties. The commissioner shall have the following powers and duties: 1. to promulgate regulations defining and restricting the duties which may be assigned to physician assistants by their supervising physician, the degree of supervision required and the manner in which such duties may be performed;

2. to conduct and support continuing studies respecting the nature and scope of the duties of physician assistants in order to promote their effective functioning as members of the health care team;

3. to determine the desirability of and to establish rules for requiring continuing education of physician assistants;

4. to furnish the education department with suggested criteria which may be used by the education department to help determine whether an applicant for licensure as a physician assistant possesses equivalent education and training, such as experience as a nurse or military corpsman, which may be accepted in lieu of all or part of an approved program;

5. to adopt such other rules and regulations as may be necessary or appropriate to carry out the purposes of this article.

§ 3702. Special provisions. 1. Inpatient medical orders. A licensed physician assistant employed or extended privileges by a hospital may, if permissible under the bylaws, rules and regulations of the hospital, write medical orders, including those for controlled substances and durable medical equipment, for inpatients under the care of the physician responsible for the supervision of such physician assistant. Countersignature of such orders may be required if deemed necessary and appropriate by the supervising physician or the hospital, but in no event shall countersignature be required prior to execution.

2. Withdrawing blood. A licensed physician assistant or certified nurse practitioner acting within his or her lawful scope of practice may supervise and direct the withdrawal of blood for the purpose of determining the alcoholic or drug content therein under subparagraph one of paragraph (a) of subdivision four of section eleven hundred ninety-four of the vehicle and traffic law, notwithstanding any provision to the contrary in clause (ii) of such subparagraph.

3. Prescriptions for controlled substances. A licensed physician assistant, in good faith and acting within his or her lawful scope of practice, and to the extent assigned by his or her supervising physician, may prescribe controlled substances as a practitioner under article thirty-three of this chapter, to patients under the care of such physician responsible for his or her supervision. The commissioner, in consultation with the commissioner of education, may promulgate such regulations as are necessary to carry out the purposes of this section.

§ 3703. Statutory construction. A physician assistant may perform any function in conjunction with a medical service lawfully performed by the physician assistant, in any health care setting, that a statute authorizes or directs a physician to perform and that is appropriate to the education, training and experience of the licensed physician assistant and within the ordinary practice of the supervising physician. This section shall not be construed to increase or decrease the lawful scope of practice of a physician assistant under the education law.

ARTICLE 37-A

SPECIALIST ASSISTANTS

Section 3710. Definitions.

3711. Commissioner; powers and duties.

§ 3710. Definitions. As used in this article:

1. Specialist assistant. The term "specialist assistant" means a person who is registered pursuant to section sixty-five hundred forty-eight of the education law as a specialist assistant for a particular medical speciality as defined by regulations promulgated by the commissioner pursuant to section thirty-seven hundred eleven of this article.

2. Physician. The term "physician" means a practitioner of medicine licensed to practice medicine pursuant to article one hundred thirty-one

of the education law.

3. Hospital. The term "hospital" means an institution or facility possessing a valid operating certificate issued pursuant to article twenty-eight of this chapter and authorized to employ specialist assistants in accordance with rules and regulations of the public health and health planning council.

4. Approved program. The term "approved program" means a program for the education of specialist assistants which has been formally approved by the education department.

§ 3711. Commissioner; powers and duties. The commissioner shall have the following powers and duties:

1. to promulgate regulations defining and restricting the duties which may be assigned to specialist assistants, the degree of supervision required and the manner in which such duties may be performed;

2. to promulgate regulations establishing such different medical specialties for which specialist assistants may be registered by the education department pursuant to section sixty-five hundred forty-eight of the education law as will most effectively increase the quality of medical care available in this state; provided, however, that no category of specialist assistant shall be established: (a) for areas in which allied health professions are licensed pursuant to the education law or this chapter; or (b) relating to the practice of surgery or practice in the intensive care unit of any general hospital, as defined pursuant to article twenty-eight of this chapter.

3. to conduct and support continuing studies respecting the nature and scope of the duties of specialist assistants in order to promote their effective functioning as members of the health care team;

4. to determine the desirability of and to establish rules for requiring continuing education of specialist assistants;

5. to furnish the education department with suggested criteria which may be used by the education department to help determine the education and training requirements for a specialist assistant;

6. to adopt such other rules and regulations as may be necessary or appropriate to carry out the purposes of this article.

ARTICLE 38

VETERANS HEALTH MANPOWER CENTER

Section 3800. Policy and purposes of article.

3801. Veterans health manpower center.

3802. Powers and duties.

3803. Veterans health care information program.

§ 3800. Policy and purposes of article. The availability of adequate numbers of competent personnel for the provision of health services required by the people of the state is essential to the public health. Many of those returning from duty with the armed services possess experience acquired during assignment to military hospitals or other medically connected duty for which there exists a critical need in civilian health service fields. It is the policy of the state to utilize this valuable resource in the protection and promotion of the health of the inhabitants of the state.

For that purpose the department of health is hereby vested with responsibility for the identification of veterans health manpower resources and the recruitment and qualification of veterans having experience in health fields for employment in health service occupations.

§ 3801. Veterans health manpower center. The commissioner shall establish within the department a veterans health manpower center for the purpose of instituting and conducting studies and surveys of

veterans health manpower resources, maintaining registries of such resources and recruiting veterans having experience in health fields for employment in health service occupations.

§ 3802. Powers and duties. 1. The veterans health manpower center shall have the following duties:

(a) To identify veterans health manpower resources.

(b) To conduct studies and surveys of health needs to determine the extent to which such needs can be filled by veterans with health service experience.

(c) To institute and operate a veterans health manpower recruiting service including, but not limited to, a guidance and counselling service.

2. In the exercise of the foregoing powers and duties the commissioner shall consult with the commissioner of the department of veterans' services and the heads of state agencies charged with responsibility for manpower and health resources.

§ 3803. Veterans health care information program. 1. There is hereby created within the department the veterans health care information program (referred to in this section as the "program"), which shall provide information on health issues associated with military duty, including but not limited to Agent Orange, spina bifida, Gulf War Syndromes, toxic materials or harmful physical agents such as, depleted uranium, and hepatitis C, and specific mental and physical health issues including post-traumatic stress disorder, traumatic brain injury and other brain-related injuries, for veterans, their surviving spouses, children of veterans and health care providers.

2. The program shall include but not be limited to the following elements:

(a) public service announcements;

(b) establishment of a toll-free telephone hotline to provide information regarding health care providers and treatment centers with

expertise in illnesses associated with military duty; and

(c) establish a veterans health information clearing house on-line.

3. In exercising any of his or her powers under this section, the commissioner shall consult with appropriate health care professionals, providers, veterans or organizations representing them, the department of veterans' services, the United States department of veterans affairs and the United States defense department.

4. The commissioner may make rules and regulations necessary and appropriate for the implementation of this section.

ARTICLE 39

NEW YORK STATE CENTER FOR AGRICULTURAL MEDICINE AND HEALTH

Section 3900. Legislative findings and purposes.

3901. Definitions.

3902. New York state center for agricultural medicine and health.

3903. Purposes of the center.

3904. Contributions.

3905. Funds.

3906. Contract authority.

3907. Agricultural health and safety advisory board.

3908. Annual report.

§ 3900. Legislative findings and purposes. 1. The legislature hereby finds, determines, and declares that promotion of the continued health and safety of New York state's farming community continues to be an unmet need. It further finds that agriculture is ranked as the most dangerous occupation on a nationwide basis and that farmers and other agricultural workers are injured and killed at a rate four times greater than other workers in the country: in nineteen hundred eighty-five, forty-five deaths and over four thousand farm-related injuries were reported within New York state.

2. The provision of health and safety services unique to the agricultural sector has been seen by many physicians as relatively unattractive. As a consequence, the medical profession lacks specific knowledge of, and expertise in, treating farm illnesses. While some progress has been made to date in the area of farm health and safety, more work is needed to address such specific concerns as traumatic injury, hearing loss, and occupational cancer. Further efforts need to be made to provide educational programs to improve awareness of agricultural health concerns, and to enhance delivery of targeted agricultural health services in the state.

3. It is vital that the state of New York develop a capability to address the special health and safety needs of the state's farming community. In order to facilitate a focus on agricultural medicine and health, the legislature hereby determines that there is a need to create a New York state center for agricultural medicine and health to operate in conjunction with the Mary Imogene Bassett Hospital, Cooperstown, New York.

§ 3901. Definitions. For purposes of this article, the following terms shall have the following meanings:

1. "Center" shall mean the center for agricultural medicine and health to be established in conjunction with the Mary Imogene Bassett Hospital of Cooperstown, New York.

2. "Director" shall mean the director of the center for agricultural medicine and health.

3. "Board" shall mean the agricultural health and safety advisory board.

§ 3902. New York state center for agricultural medicine and health. There is hereby established a center for agricultural medicine and health to operate in conjunction with the Mary Imogene Bassett Hospital,

Cooperstown, New York. Such center shall operate under the guidance of a director, who shall be appointed by the board of trustees of the Mary Imogene Bassett Hospital, Cooperstown, New York upon the advice and consent of the president of such hospital.

§ 3903. Purposes of the center. In order to more effectively serve the health and medical needs of the state's agricultural community, the center shall:

1. develop strategies for the provision of comprehensive occupational health services for New York farmers and agricultural workers, including but not limited to migrant workers;

2. research and develop information on the epidemiology of farm-related occupational illness;

3. compile resource material relating to agricultural medicine and preventive health care;

4. provide continuing agricultural health and medical education programs for physicians and other health care personnel and service providers practicing within the state;

5. provide education and other service programs to farmers and agricultural workers on agricultural health and safety issues; and

6. establish relations with existing health care and agricultural interest groups to ensure appropriate, targeted delivery of agricultural health and safety services and information.

§ 3904. Contributions. The center is authorized to receive any grant or contribution from any person, association, or public or private corporation.

§ 3905. Funds. The center is authorized to disburse funds to carry out its programs and activities.

§ 3906. Contract authority. The center is hereby authorized to enter into agreements or contracts with any public or private agency, corporation, or individual in order to carry out the provisions of this article. Funds made available by the center pursuant to this article shall be provided pursuant to the terms of such contracts.

§ 3907. Agricultural health and safety advisory board. 1. There is hereby created an advisory board to be known as the "agricultural health and safety advisory board", to be comprised of twelve members consisting of the following named persons or their designees: the commissioner of health; the commissioner of agriculture and markets; the dean of the school of public health sciences at the state university of New York at Albany; the dean of the college of agriculture and life sciences at Cornell university; and eight additional members, one of whom shall be appointed by the governor and shall be a representative of a county cooperative extension, one of whom shall be appointed by the governor and shall be a representative of rural New York, six of whom shall be representatives of general farm organizations, or individual farmers with annual gross sales of ten thousand dollars or more, or individuals involved in providing health and safety services in counties with fewer than two hundred thousand persons, or members of farm workers organizations, to be appointed as follows: two by the temporary president of the senate, two by the speaker of the assembly, one by the minority leader of the senate, and one by the minority leader of the assembly. Members of the board shall elect a chairperson on an annual basis.

2. Members of the board shall receive no salary, but shall be reimbursed by the director for expenses actually and necessarily incurred by them in the performance of their duties as described hereunder.

3. Vacancies on the board shall be filled in the same manner as the original appointments.

4. The director shall cause the center to provide staff assistance necessary for the efficient and effective operation of the board.

5. The board shall render advice regarding:

a. statewide needs to be addressed by the center;

b. the coordination of program activities with state agencies, not-for-profit corporations and other interested parties;

c. dissemination of research results and educational information; and

d. identification of funding sources for center program.

§ 3908. Annual report. The director, in cooperation with the advisory board, shall report the activities of the center to the governor and the legislature on or before January first of each year. Such report shall include:

1. A description of on-going center research and program development;

2. Present and proposed working relationships with other agencies, not-for-profit groups or private associations;

3. A financial reporting on the nature and levels of revenues and expenditures of the center, as well as a listing of accumulated assets; and

4. Recommendations for enhancing agricultural health and safety in New York state.

HOSPICE

- Section 4000. Legislative declaration.
- 4002. Definitions.
- 4004. Establishment of hospices.
- 4006. Hospice construction.
- 4008. Certification of hospices.
- 4010. Powers and duties of the commissioner and the state hospital review and planning council.
- 4011. Quality assurance.
- 4012. Payment for hospice.
- 4012-a. Hospice supplemental financial assistance program for persons with special needs.
- 4012-b. Hospice palliative care.
- 4013. Hospice worker recruitment and retention program.
- 4013-b. Home care services worker registry.
- 4014. Hospice residence pilot program.
- 4015. Pilot program for all-inclusive care for children.

§ 4000. Legislative declaration. The legislature finds and declares that hospice is a socially and financially beneficial alternative to conventional curative care for those afflicted by terminal illness. It further finds that hospice is a unique, interdisciplinary program of palliative and supportive care to meet the stresses associated with illness, death and bereavement through the innovation and reorganization of home and traditional inpatient health services.

In recognition of the value of hospice and consistent with state policy to encourage the expansion of health care service options available to New York state residents, it is the intention of the legislature that hospice be available to all who seek such care and that it become a permanent component of the state's health care system.

§ 4002. Definitions. As used in this article, the following words and phrases shall have the following meanings:

1. "Hospice" means a coordinated program of home and in-patient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement.

2. "Hospice demonstration program participant" means a hospice which was approved to participate in the hospice demonstration program established pursuant to chapter seven hundred eighteen of the laws of nineteen hundred seventy-eight and is operating on the thirtieth day of June, nineteen hundred eighty-three.

2-a. "Home" shall include a hospice patient's home or a hospice residence.

2-b. "Hospice residence" means a hospice operated home which is residential in character and physical structure and operated for the purpose of providing more than two hospice patients but not more than sixteen hospice patients with hospice care, which may include dually certified hospice in-patient beds up to one hundred percent of the hospice residence's patient capacity.

3. "Construction" means construction as defined in section thirty-six hundred two of this chapter.

4. "Public health council" and "state hospital review and planning council" shall mean the public health and health planning council.

5. "Terminally ill" means an individual has a medical prognosis that the individual's life expectancy is approximately one year or less if the illness runs its normal course.

§ 4004. Establishment of hospices. 1. The commissioner shall not issue a certificate of approval to any hospice except with the written

approval of the public health and health planning council. However, a hospice demonstration program participant making application to the commissioner solely to establish a hospice shall be deemed to have met such requirement.

2. An application for approval of the proposed hospice shall be filed with the public health and health planning council together with such other forms and information as shall be prescribed by, or acceptable to, the public health and health planning council. Thereafter, the public health and health planning council shall forward a copy of the proposed application for establishment and accompanying documents to the health systems agency, if any, having geographical jurisdiction of the area where the services of the proposed hospice are to be offered. The public health and health planning council shall act upon such application after the health systems agency has had a reasonable time to submit its recommendations. At the time members of the public health and health planning council are notified that an application is scheduled for consideration, the applicant and the health systems agency shall be so notified in writing. The public health and health planning council shall not take any action contrary to the advice of the health systems agency until it affords to the health system agency an opportunity to request a public hearing and, if so requested, a public hearing shall be held. If the public health and health planning council proposes to disapprove the application, it shall afford the applicant an opportunity to request a public hearing. The public health and health planning council may hold a public hearing on the application on its own motion. Any public hearing held pursuant to this subdivision may be conducted by the public health and health planning council or by any individual designated by the public health and health planning council. The public health and health planning council shall not approve an application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the hospice at the time and place and under the circumstances proposed; (b) the character, competence, and standing in the community, of the proposed incorporators, directors, sponsors, stockholders or operators; (c) the financial resources of the proposed hospice and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

3. (a) No hospice shall be approved for establishment which would be operated by a corporation any of the stock of which is owned by another corporation.

(b) Any change in the person, principal stockholder or partnership which is the operator of a hospice shall be approved by the public health and health planning council in accordance with the provisions of subdivisions one and two of this section.

4. (a) The public health and health planning council, by a majority vote of its members, shall adopt and amend rules and regulations, to effectuate the provisions and purposes of this section, and to provide for the revocation, limitation or annulment of approvals of establishment.

(b) (i) No approval of establishment shall be revoked, limited or annulled without first offering the person who received such approval the opportunity of requesting a public hearing, (ii) the commissioner, at the request of the public health and health planning council, shall fix a time and place for any such hearing requested, (iii) notice of the time and place of the hearing shall be served in person or mailed by registered mail to the person who has received establishment approval at least twenty-one days before the date fixed for the hearing, (iv) such person shall file with the department, not less than eight days prior to the hearing, a written answer, (v) all orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of such order or determination.

5. (a) The commissioner shall charge to applicants for the establishment of a hospice an application fee in the amount of two thousand dollars.

(b) An applicant for both establishment and construction of a hospice shall not be subject to this subdivision and shall be subject to fees and charges as set forth in section four thousand six of this article.

(c) All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other,

miscellaneous special revenue fund - 339, certificate of need account.

§ 4006. Hospice construction. 1. The construction of a hospice shall require the prior approval of the commissioner.

2. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the public health and health planning council and the health systems agency, if any, having geographical jurisdiction of the area where the hospice is located.

3. The commissioner shall not act upon an application for construction unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health and health planning council pursuant to the provisions of this article) and until the public health and health planning council and the health systems agency concerned have had a reasonable time to submit their recommendations, and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed.

4. Subject to the provisions of paragraph (b) of subdivision three of this section, the commissioner in approving the construction shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services which currently serve as alternatives or substitutes for the whole or any part of the proposed construction; (b) the need for program changes in view of existing utilization at the time and place and under the circumstances proposed; (c) the adequacy of financial resources and sources of future revenue; and (d) whether the hospice has been operated in substantial compliance with all applicable laws, rules and regulations.

5. In determining whether there is a public need for the proposed construction pursuant to subdivisions three and four of this section,

the commissioner shall consider the advice of the state health planning and development agency designated pursuant to the provisions of the national health planning and resources development act of nineteen hundred seventy-four and any amendments thereto.

6. No governmental agency shall construct a hospice without securing the written approval of the commissioner in accordance with the applicable requirements and procedures of the preceding subdivisions.

7. If the commissioner proposes to disapprove an application for construction of a hospice, he shall afford the applicant an opportunity to request a public hearing. The commissioner shall not take any action contrary to the advice of the health systems agency until he affords an opportunity to the agency to request a public hearing and, if so requested, a public hearing shall be held.

8. The commissioner, on his own motion, may hold a public hearing on an application for construction of a hospice.

9. (a) The commissioner shall charge to applicants for construction of a hospice an application fee of two thousand dollars.

(b) At such time as the commissioner's written approval of the construction is granted, each such applicant shall pay an additional fee of thirty hundredths of one percent of the total capital value of the application.

(c) All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue fund - other, miscellaneous special revenue fund - 339, certificate of need account.

§ 4008. Certification of hospices. 1. The commissioner shall not issue a certificate of approval to any hospice unless it complies with the provisions of this article and the rules and regulations promulgated pursuant thereto, in accordance with the standards and procedures adopted by the state hospital review and planning council, and is qualified to participate as a hospice under title XVIII of the Federal Social Security Act, provided, however that the commissioner shall issue

a certificate of approval to a hospice if he is satisfied that the hospice cannot qualify to participate as a hospice under title XVIII of the Federal Social Security Act solely because it proposes to provide nursing services by arrangement with a certified home health agency. No person, partnership or organization shall hold itself out as a hospice unless it shall possess a valid certificate of approval.

2. Any hospice demonstration program participant applying for a certificate of approval by the first day of June nineteen hundred eighty-four and meeting all applicable standards shall be issued a certificate of approval.

3. Subject to the provisions of this section and section four thousand ten of this article, contractual agreements between a hospice and other providers of other care and services shall not be prohibited, and a hospice may employ and enter into contracts with any licensed healthcare professional or any lawful combination thereof in relation to services provided by the hospice under this article, provided that the hospice maintains full responsibility for the planning, coordination and quality of such services and the adherence to the plan of care established for the patients.

4. A hospice certificate of approval may be revoked, suspended, limited or annulled by the commissioner on proof that the hospice has failed to comply with the provisions of this article or rules and regulations promulgated thereunder.

5. No hospice certificate of approval shall be revoked, suspended, limited or annulled without a hearing. However, a certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the hospice following a finding by the department that the public health or safety is in imminent danger.

6. The commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or

certified mail to the hospice at least twenty-one days before the date fixed for the hearing. The hospice shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

7. All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order or determination upon the applicant.

8. (a) Notwithstanding the provisions of subdivisions five through seven of this section, the commissioner shall suspend, limit or revoke a hospice certificate of approval after taking into consideration the public need for the hospice and the availability of other services which may serve as alternatives or substitutes, and after finding that suspending, limiting, or revoking the certificate of approval of the hospice would be within the public interest in order to conserve health resources by restricting the level of services to those which are actually needed.

(b) Whenever any finding as described in paragraph (a) of this subdivision is under consideration with respect to any particular hospice, the commissioner shall cause to be published, in a newspaper of general circulation in the geographic area of the hospice, at least thirty days prior to making such a finding an announcement that such finding is under consideration and an address to which interested persons can write to make their views known. The commissioner shall take all public comments into consideration in making such a finding.

(c) The commissioner shall, upon making any finding described in paragraph (a) of this subdivision with respect to any hospice, cause such hospice and the appropriate health systems agency to be notified of the finding at least thirty days in advance of taking the proposed action to revoke, suspend or limit the hospice's certificate of approval. Upon receipt of any such notification and before the expiration of the thirty days or such longer period as may be specified in the notice, the hospice or the appropriate health systems agency may request a public hearing to be held in the county in which the hospice

is located. In no event shall the revocation, suspension or limitation take effect prior to the thirtieth day after the date of the notice, or prior to the effective date specified in the notice or prior to the date of the hearing decision, whichever is later.

(d) Except as otherwise provided by law, all appeals from a finding of the commissioner made pursuant to paragraph (a) of this subdivision shall be directly to the appellate division of the supreme court in the third department. Except as otherwise expressly provided by law, such appeals shall have preference over all issues in all courts.

§ 4010. Powers and duties of the commissioner and the state hospital review and planning council. 1. The commissioner shall have the power to conduct periodic inspections of hospices with respect to the fitness and adequacy of equipment, personnel, rules and bylaws, standards of service and medical care, system of accounts, records, and the adequacy of financial resources and sources of future revenues.

2. The commissioner shall seek from the federal government any waivers necessary to obtain medicare reimbursement for services provided by hospices which provide nursing services by arrangement with a certified home health agency. Subject to the approval of the director of the budget, the commissioner is authorized to seek any other federal waivers he deems necessary to improve the provision of hospice services.

3. Each hospice shall submit annually to the commissioner a complete description of its operation, including name, address, principal place of business, ownership, identification of the administrative personnel and members of the interdisciplinary team, the nature and extent of palliative and supportive care, the functions and activities performed by volunteers, a copy of all contracts and agreements entered into for the care and services it provides under arrangement, and such other information as the commissioner shall require. The commissioner shall set an annual date for submission of such information.

4. The state hospital review and planning council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to

the approval of the commissioner, to effectuate the provisions and purposes of this article with respect to hospices including, but not limited to, (a) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of services provided and their utilization and costs; (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges; (c) standards and procedures relating to certificates of approval for hospices; (d) uniform standards for quality of care services to be provided by hospices; (e) requirements for minimum levels of staffing, taking into consideration the size of the hospice or the type of care and service provided, and the special needs of the persons served; (f) standards and procedures relating to contractual arrangements between hospices and other providers of care including the provision of nursing services by contract; (g) requirements for uniform review of the appropriate utilization of services; (h) requirements for minimum qualifications and standards of training for personnel as appropriate; (i) requirements to assure that certified hospices assume total responsibility for hospice patients, including direction and coordination of all care; and (j) requirements relating to fire safety in those portions of hospice residences in which hospice patients reside and receive care, which requirements shall establish standards identical to those set forth for small residential board and care facilities in chapter 21, section 21-2 of the 1985 National Fire Protection Association 101 Life Safety Code, as in effect on the effective date of this paragraph. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

§ 4011. Quality assurance. 1. Every hospice is required to establish a quality assurance program which shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided by the hospice.

2. The information required to be collected and maintained by hospices pursuant to subdivision one of this section and as required by subdivision four of section four thousand ten of this article shall be kept confidential and shall not be released except to the department;

provided, however, that such information shall be released to a law enforcement agency upon a court order based upon probable cause that such information: (a) is relevant to a criminal investigation or proceeding and (b) cannot be obtained through any other means. Nothing in this section shall prohibit a hospice from voluntarily releasing what it reasonably believes to be evidence of criminality to a law enforcement agency.

3. Notwithstanding any other provision of law, none of the records, documentation or committee actions or records required to be maintained by hospices pursuant to subdivision one of this section and as required by subdivision four of section four thousand ten of this article shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibitions of this subdivision shall not apply to statements made by any person in attendance at such a meeting who is a party, or employee or agent of a party to any action or proceeding the subject matter of which was reviewed at such meeting. Nothing contained in this subdivision shall prohibit disclosure of records, documentation or committee actions or records relating to employment history and recommendations from being transmitted to any hospice which is required by law or regulation to obtain such information.

4. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person, partnership, corporation, firm, society or other entity on account of participating in good faith and with reasonable care in a quality assurance committee or the communication of information in the possession of such person or entity, or on account of any recommendation or evaluation, regarding the qualifications, fitness, conduct or practices of any officer, director, employee, or agent of such hospice to any government agency, professional society, licensing or certification board as required by subdivision one of this section and subdivision four of section four thousand ten of this article. The foregoing shall not apply to

information which is untrue and communicated with malicious intent.

§ 4012. Payment for hospice. 1. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for services provided by a hospice unless, at the time the services were provided, the hospice possessed a valid certificate of approval.

2. Payments for hospice care made by government agencies shall be at rates approved by the state director of the budget.

3. Prior to the approval of hospice rates, the commissioner shall determine and certify to the state director of the budget that the proposed rate schedules for payments for hospice services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated programs. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospice is located, costs of hospice programs of comparable size, the need for incentives to improve services and institute economies, and applicable medicare reimbursement regulations.

4. Eligible individuals shall be permitted to receive hospice services from a provider under this article while continuing to reside in an adult care facility under title two of article seven of the social services law and enrolled in the assisted living program, subject to the availability of federal financial participation. The commissioner shall make regulations and take other actions reasonably necessary and appropriate to implement this subdivision.

5. The commissioner shall establish a methodology as of July first, two thousand eighteen subject to federal financial participation that shall ensure a prospective ten-percent increase in the medicaid reimbursement rates for hospice providers, relative to the reimbursement rate, as of March thirty-first, two thousand eighteen, for services provided by such providers on and after April first, two thousand

eighteen.

§ 4012-a. Hospice supplemental financial assistance program for persons with special needs. 1. Notwithstanding any provision of law or regulation to the contrary, an additional amount may be added to a hospice's rate pursuant to the medical assistance program, subject to approval by the state director of the budget, for purposes of enabling such hospice to provide care and services to persons with special needs, after a determination that such care cannot be appropriately provided at the rates of payment established pursuant to federal criteria.

2. "Persons with special needs" as used herein shall include persons with acquired immune deficiency syndrome and other illnesses or conditions, which require a more costly or intensive level of care than typically provided, and persons receiving care in a hospice residence. Such other illnesses or conditions shall be specified in regulation by the state hospital review and planning council.

3. In order for a hospice to obtain additional medicaid payment as provided for in this section, the hospice shall submit cost information as required by the commissioner, in consultation with the commissioner of social services, which justifies additional medicaid expenditures, including a demonstration that adequate care to persons with special needs cannot be provided within the rates of payment established pursuant to federal criteria. In addition to demonstrating that the hospice is certified and in good standing with all applicable regulations and requirements, the hospice shall also demonstrate that it shall:

(a) utilize such additional payment to provide services to persons with special needs;

(b) shall undertake reasonable efforts to maintain financial support from public and community contributed funding sources;

(c) shall make every reasonable effort to collect payments for services from third party insurance payers, governmental payers and self-paying patients; and

(d) shall establish a reasonable relationship between costs and

charges, or establish charges at approximate costs.

4. The commissioner, in consultation with the commissioner of social services, is authorized to submit for approval and adoption by the state hospital review and planning council such regulations as necessary to effectuate the provisions of this section.

5. The commissioner shall establish a rate for persons receiving care in a hospice residence, and may by regulation specify additional standards necessary to ensure that the provisions of this section promote medical assistance recipients access to hospice residence care including; (a) that such recipients are otherwise unable to appropriately receive hospice care in their own home; and (b) the provision of supplemental financial assistance will promote the efficient delivery of appropriate, quality, cost-effective services.

§ 4012-b. Hospice palliative care. 1. Notwithstanding any inconsistent provision of this article to the contrary, a hospice may also offer a program of palliative care for patients with advanced life-limiting conditions and illnesses and their families. Such a program may be provided by a hospice issued a certificate of approval pursuant to section four thousand four of this article, acting alone or under contract with a certified home health agency, long term home health care program, licensed home care services agency or AIDS home care program, as such terms are defined in section thirty-six hundred two of this chapter. Nothing in this section shall preclude the provision of palliative care by any other health care provider otherwise authorized to provide such services.

2. For the purposes of this section "Palliative care" means the active, interdisciplinary care of patients with advanced, life-limiting illness, focusing on relief of distressing physical and psychosocial symptoms and meeting spiritual needs. Its goal is achievement of the best quality of life for patients and families.

§ 4013. Hospice worker recruitment and retention program. 1. The commissioner shall, subject to the provisions of subdivision two of this section, increase medical assistance rates of payment by up to three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

2. Hospice services providers which have their rates adjusted pursuant to this section shall use such funds for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility only and are prohibited from using such funds for any other purposes. Funds provided pursuant to this section are not intended to supplant support provided by a local government. Each such provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup all funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or workers with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

§ 4013-b. Home care services worker registry. A hospice program providing hospice care in a patient's home shall comply with the home care services worker registry under section thirty-six hundred thirteen of this chapter.

§ 4014. Hospice residence pilot program. 1. The commissioner is hereby authorized to establish a hospice residence pilot program. Such program, subject to the rules and regulations of the commissioner, shall authorize the operation of not more than ten hospice residences operated for the purpose of providing more than two hospice patients but not more

than sixteen hospice patients with hospice care. The locations of the hospice residence pilot program shall be geographically disbursed throughout the state and approved by the commissioner. To the extent that patients may access hospital or skilled nursing home care, the care plan for such patients shall provide for such care.

2. The commissioner shall require each hospice residence participating in the pilot program established pursuant to this section to submit a report, which shall include data analyzing the cost and efficiency of hospice care under such pilot program. On or before December thirty-first, two thousand seven, the commissioner shall submit a report to the governor, the temporary president of the senate and the speaker of the assembly analyzing the findings of the individual hospice residences that participated in the pilot program.

§ 4015. Pilot program for all-inclusive care for children. 1. The commissioner is hereby authorized to establish a pilot program for all-inclusive care for children. Such program, subject to the rules and regulations of the commissioner, shall consist of comprehensive hospice and palliative care services for children with life-limiting illnesses that addresses the medical, psychosocial and spiritual aspects of care and allows such children to be cared for at home rather than in an institutional setting. Such services shall be provided by a licensed, certified hospice working jointly with a certified home health agency, or a certified home health agency working jointly with a licensed, certified hospice to assure the provision of services which are an enhancement of either the certified home health agency or hospice alone, and shall include hospice services as well as related expressive therapies such as art, play or music therapy in addition to services of a child life specialist, and opportunities for respite care.

2. "A child with a life threatening illness" shall mean a child eligible for medical assistance under article five of the social services law, who under the age of eighteen is diagnosed with an illness that places the child at substantial risk of dying before the age of twenty-one where the child can, with appropriate services be cared for

at an alternative to institutional care.

3. Qualified agencies providing services under this section to a child shall be reimbursed under medical assistance under article five of the social services law, at a per diem rate for each day the child is enrolled in a program. To ensure the alienability of needed services to these children, reimbursement shall be provided only to those agencies having satisfied conditions of the department including satisfactory training in pediatric palliative care.

4. Certified hospice programs shall be allowed to waive the admission criteria requiring certification of "a terminal illness with prognosis of six months or less" as well as the requirement for families to forgo curative treatment for children qualifying for this program receiving care from an approved site.

5. All home care and other medical assistance under article five of the social services law otherwise authorized for the child, shall continue without interruption. The pilot program for all-inclusive care for children is not intended to supersede any program already in place.

6. The locations of the providers under the pilot program for all-inclusive care shall be geographically disbursed throughout the state and approved by the commissioner.

7. The commissioner shall require each provider under the pilot program for all-inclusive care for children to submit an annual report, which shall include data analyzing the cost and efficiency of care provided under such program. On or before December thirty-first, two thousand eight, the commissioner shall submit a report to the governor, the temporary president of the senate and the speaker of the assembly analyzing the cost and efficiency of the pilot program.

ARTICLE 41

VITAL STATISTICS

Title I. General provisions (Secs. 4100-4104).

- II. Registration districts: registrars, physicians, midwives and funeral directors (Secs. 4120-4124).
- III. Registration of births (Secs. 4130-4138-e).
- III-A. Filing of certificates of dissolution of marriage (Sec. 4139).
- IV. Registration of deaths: burial permits (Secs. 4140-4148).
- V. Registration of fetal deaths (Secs. 4160-4163).
- V-A. Induced viable births.
- VI. Registration of persons in institutions (Sec. 4165).
- VII. Vital statistics records (Secs. 4170-4179).

TITLE I

GENERAL PROVISIONS

- Section 4100. Vital statistics; functions, powers and duties of the department, commissioner and public health council.
- 4100-a. Definitions.
 - 4101. Vital statistics; enforcement.
 - 4102. Vital statistics; violations; penalties.
 - 4103. Vital statistics; evidence.
 - 4104. Vital statistics; application of article.

§ 4100. Vital statistics; functions, powers and duties of the department, commissioner and public health council. 1. The department shall, except in the city of New York:

- (a) have charge of the registration of births and deaths;
- (b) procure the faithful registration of births and deaths;
- (c) provide the necessary instructions and forms for obtaining and preserving records of births and deaths; and,
- (d) be charged with the uniform and thorough enforcement of the provisions of this article throughout the state.

2. The commissioner shall:

- (a) have general supervision of vital statistics;
- (b) provide suitably equipped offices for the permanent and safe preservation of all records received or made under the provisions of

this article;

(c) prepare, print, and supply to all registrars all forms used in registering, recording and preserving the returns, or in otherwise carrying out the purposes of this article;

(d) prepare and issue such detailed instructions, not inconsistent with the sanitary code, as may be required to procure the uniform observance of the provisions of this article and the maintenance of a good system of registration;

(e) examine the certificates received monthly and if any such are incomplete or unsatisfactory, he shall require such further information to be supplied as may be necessary to make the record complete and satisfactory;

(f) arrange, and permanently preserve the certificates in a systematic manner;

(g) prepare and maintain a complete typewritten, printed, photographic or magnetically stored index of all births and deaths registered; said index to be arranged, in the case of deaths, by the names of decedents, and in the case of births, by the names of fathers, or the names of mothers if the names of the fathers do not appear; and

(h) prescribe and prepare the necessary methods and forms for obtaining and preserving records and statistics of autopsies which are conducted by a coroner or by a medical examiner, or by his order, within the state of New York, and shall require all those performing such autopsies, for the purpose of determining the cause of death or the means or manner of death, to enter upon such record the pathological appearances and findings embodying such information as may be prescribed, and to append thereto the diagnosis of the cause of death and the means or manner of death.

(i) upon notification by the division of criminal justice services that a person who was born in the state is a missing child, flag the certificate record of that person in such manner that whenever a copy of the record is requested, he or she shall be alerted to the fact that the record is that of a missing child. The commissioner shall also notify the appropriate registrar to likewise flag his or her records. The commissioner or registrar shall immediately report to the local law enforcement authority and the division of criminal justice services any request concerning flagged birth records or knowledge as to the

whereabouts of any missing child. Upon notification by the division of criminal justice services that the missing child has been recovered, the commissioner shall remove the flag from the person's certificate record and shall notify any other previously notified registrar to remove the flag from his or her record. In the city of New York, the commissioner of the department of health for the city of New York shall implement the requirements of this paragraph.

3. The public health council may from time to time establish such rules and regulations in the sanitary code supplementary to the provisions of this article and not inconsistent therewith, as it may deem necessary, in relation to the registration of births, deaths and fetal deaths. Such rules and regulations shall be observed by all persons upon whom duties are imposed by this chapter in connection with the registration of births, deaths and fetal deaths.

4. Certified nurse practitioners completing a death certificate for a death occurring in the city of New York shall have the same authority and responsibility to complete the certificate as they would have if the death occurred outside such city; provided, however, that such responsibility shall be exercised in accordance with the rules and regulations of the city of New York.

§ 4100-a. Definitions. As used or referred to in this article:

1. The term "certified copy" means a photographic reproduction in the form of a photocopy or a microfilm print of the original certificate or electronically produced print of the original certificate, commencing on or after the implementation date under section forty-one hundred forty-eight of this title, and certified by the commissioner, his designated representative, a local registrar, deputy registrar or sub-registrar as a true copy thereof.

2. The term "certified transcript" means a computer generated or other reproduction of information abstracted from the original state or local record the elements of which shall be as determined by the commissioner

and certified by the commissioner, his designated representative, a local registrar or a deputy registrar as being an accurate abstract of information contained in the original record.

3. The term "certification of birth" means a certification that a certificate of birth is on file and shall contain only the name, sex, date of birth and place of birth of the person to whom it relates and none of the other data on a certificate of birth. When issued by the local registrar or his deputy, it shall also contain the date of filing of the certificate of birth. When issued by the commissioner or by his designated representative, it shall also contain the dates of filing in the local registration district, or a statement that the birth certificate was filed within one year of the date of birth, and in the state department of health of the original certificate of birth.

4. A "certification of death" shall contain only the name, the date of death, and the place of death of the person to whom it relates, the date of filing in the local registration district, or a statement that the death certificate was filed within one year of the death of the person to whom it relates, and none of the other data on the certificate of death.

5. The term "electronic death registration system" means the data system created and maintained by the department for collecting, storing, recording, transmitting, amending, correcting and authenticating information, as necessary and appropriate to complete a death registration, and to generate such documents as determined by the department, including permits or certificates, relating to a death occurring in this state.

§ 4101. Vital statistics; enforcement. 1. The commissioner is hereby charged with the execution of the provisions of this article and is hereby granted supervisory power over registrars, deputy registrars, and subregistrars, to the extent that there shall be uniform compliance with all of the requirements of this article.

2. Each registrar is hereby charged with the enforcement of the provisions of this article in his registration district, under the supervision and direction of the commissioner. He shall make an immediate report to the commissioner of any violation of any provision of this article coming to his knowledge, by observation, or upon complaint of any person, or otherwise.

3. The commissioner, either personally or by an accredited representative, shall have authority to investigate cases of irregularity, or violation of law, and all registrars shall aid him, upon request, in such investigations.

4. When he shall deem it necessary, the commissioner shall report cases of violation of any of the provisions of this article to the district attorney of the county, with a statement of the facts and circumstances. When any such case is reported to him by the commissioner, the district attorney shall forthwith initiate and promptly proceed with the necessary court proceedings against the person, firm or corporation responsible for the alleged violation of law.

5. Upon request of the commissioner, the attorney general shall assist in the enforcement of the provisions of this article.

§ 4102. Vital statistics; violations; penalties. 1. Any person shall be deemed guilty of a misdemeanor, and upon conviction thereof shall for the first offense be fined not less than five dollars nor more than fifty dollars and for each subsequent offense not less than ten dollars or more than one hundred dollars or be imprisoned in the county jail not more than sixty days, or be both fined and imprisoned in the discretion of the court, who for himself or as an officer, agent, or employee of any other person, or of any corporation or partnership, shall:

(a) refuse or fail to furnish correctly any information in his possession, or shall furnish false information affecting any certificate or record, required by this article; or,

(b) wilfully alter, otherwise than is provided by this article, or

shall falsify any certificate of birth or death, or any record established by this article; or,

(c) being required by this article to fill out a certificate of death and file the same with the local registrar, or deliver it, upon request, to any person charged with the duty of filing the same, shall fail, neglect or refuse to perform such duty in the manner required by this article; or,

(d) inter, cremate, or otherwise finally dispose of the dead body of a human being, or permit the same to be done, or shall remove said body from the primary registration district in which the death occurred or the body was found, without the authority of a burial or removal permit issued by the local registrar of the district in which the death occurred, or in which the body was found, except as provided in section four thousand one hundred forty-four of this article; or,

(e) being a registrar, deputy registrar, or subregistrar, shall fail, neglect or refuse to perform his duty as required by this article and by the instructions and directions of the commissioner thereunder.

2. Whenever any physician, nurse-midwife, or other person shall fail or neglect properly to record and file a certificate of birth as required by this article such person shall be liable to a penalty of not less than five dollars nor more than fifty dollars for the first and second offenses, which penalty may be recovered by an action brought by the commissioner in any court of competent jurisdiction, and for every subsequent offense, such person shall be guilty of a misdemeanor, punishable by a fine of not less than ten nor more than one hundred dollars, or by imprisonment for not more than sixty days, or both.

§ 4103. Vital statistics; evidence. 1. Certified copies of birth certificates, certification of birth, certified or verified transcripts of birth certificates, certificates of birth data or certificates of registration of birth shall be accepted by public school authorities in this state as prima facie evidence of age of children registering for school attendance, and by the legally constituted authorities as prima facie proof of age for the issuance of employment certificates, provided that when it is not possible to secure such certified copy of the birth

certificate, certification of birth, certified or verified transcript of the birth certificate, certificate of birth data or certificate of registration of birth for any child, the school authorities may accept as secondary proof of age any of the kinds of evidence specified in the labor law.

2. Any copy of the record of a birth or of a death or any certificate of registration of birth or any certification of birth, when properly certified by the local registrar, shall be prima facie evidence of the facts therein stated in all courts and places and in all actions, proceedings, or applications, judicial, administrative or otherwise, and any such certificate of registration of birth or any such certification of birth shall be accepted with the same force and effect with respect to the facts therein stated as the original certificate of birth or a certified copy thereof.

3. A certified copy of the record of a birth or death, a certification of birth or death, a transcript of a birth or death certificate, a certificate of birth data or a certificate of registration of birth, when properly certified by the commissioner or persons authorized to act for him, shall be prima facie evidence in all courts and places of the facts therein stated.

§ 4104. Vital statistics; application of article. The provisions of this article except for the provisions contained in paragraph (i) of subdivision two and subdivision four of section four thousand one hundred, section four thousand one hundred three, subdivision two of section four thousand one hundred thirty-five, section four thousand one hundred thirty-five-b, subdivision eight of section four thousand one hundred seventy-four, paragraphs (b) and (e) of subdivision one, paragraph (a) and (b) of subdivision three, and subdivisions five and eight of section four thousand one hundred thirty-eight, subdivision eleven of section four thousand one hundred thirty-eight-c, paragraph (b) of subdivision three of section four thousand one hundred thirty-eight-d, section four thousand one hundred thirty-eight-e and section four thousand one hundred seventy-nine of this article, shall

not apply to the city of New York.

TITLE II

REGISTRATION DISTRICTS: REGISTRARS, PHYSICIANS, MIDWIVES AND FUNERAL DIRECTORS

Section 4120. Vital statistics; registration districts; establishment.

4121. Vital statistics; registrar; qualifications and appointment.

4122. Vital statistics; deputy registrars and subregistrars; appointment.

4123. Vital statistics; registrars; term of office; oath; removal.

4124. Vital statistics; registrars and subregistrars; compensation and expenses.

§ 4120. Vital statistics; registration districts; establishment. 1.

Except as otherwise provided in this article, each city, incorporated village and town in the state shall constitute a separate primary registration district, except that the commissioner may designate any county, except those comprising the city of New York, as a primary registration district with the approval of the board of supervisors of such county.

2. To facilitate registration, the commissioner may:

(a) with the approval of the legislative body of the county in which each affected district is located, combine two or more primary registration districts into a single primary registration district; or,

(b) divide one primary registration district into two or more primary registration districts; or,

(c) establish any state hospital, charitable or penal institution as a primary registration district.

3. Whenever a county or part-county primary registration district has been established or two or more primary registration districts have been combined, the records of birth and death and all papers pertaining to

such records in the possession of the original primary registration district or districts shall be transferred as directed by the commissioner.

§ 4121. Vital statistics; registrar; qualifications and appointment.

1. In each primary registration district there shall be a registrar of vital statistics.

2. Qualifications of registrars of vital statistics hereafter appointed may be prescribed by the public health council, provided that:

(a) a local health officer shall be eligible for appointment as registrar of vital statistics; and,

(b) no licensed and registered funeral director, undertaker or embalmer engaged or employed in the business or practice of funeral directing, undertaking or embalming, and no other person engaged or employed in the business of funeral directing, undertaking or embalming shall be eligible for appointment as a registrar, deputy registrar or sub-registrar of vital statistics.

3. (a) In towns and villages the registrar or registrars of vital statistics shall be appointed by the town board and by the village board of trustees respectively; a local town clerk shall be eligible for appointment as registrar of his town and of any village wholly within said town in which he has an office, and a village clerk shall be eligible for appointment as a registrar of his village and of any town in which he resides.

(b) In the cities, unless otherwise provided by charter, the registrar or registrars of vital statistics shall be appointed by the mayor.

(c) In each primary registration district consisting of a state hospital, charitable or penal institution, the registrar shall be the director or person in charge of such institution, provided, however, that he shall receive no additional remuneration for acting as such registrar.

(d) In an area designated as a county or part-county registration district, the county commissioner of health or public health director shall be appointed by the board of supervisors as registrar of such

county or part-county registration district. If there be no county commissioner of health or public health director, then the board of supervisors, with the approval of the commissioner, shall designate the registrar. When such appointment is made, the terms of office of registrars theretofore appointed within such county or part-county registration district shall thereupon terminate, and the county commissioner of health or public health director or registrar so designated shall be the registrar of the entire area embraced within such county or part-county registration district.

4. When a district is divided into two or more primary registration districts, the appointment of a registrar for each shall be made by the same appointing authority which had jurisdiction over the original district.

5. (a) When two or more primary registration districts are combined, the registrar for such combined district shall be appointed by the board or city council of those former primary registration districts having had an aggregate of one hundred or more births, deaths or fetal deaths in each of the two preceding calendar years, and which theretofore made the appointment of registrars of the original districts, except that;

(b) in a county registration district, the county commissioner of health or public health director, or if there be no county commissioner of health or public health director, the designee of the board of supervisors of such county shall be appointed as registrar for the area of his jurisdiction as provided in paragraph (d) of subdivision three of this section;

(c) where the combined primary registration districts have each registered less than an aggregate of one hundred births, deaths or fetal deaths in each of the two preceding calendar years the registrar of the combined districts, or of the districts forming a part-county registration district shall be appointed by the board of supervisors of such county.

§ 4122. Vital statistics; deputy registrars and subregistrars; appointment. 1. Immediately upon his acceptance of appointment, each

registrar of vital statistics shall appoint a deputy whose duty it shall be to act in his stead in case of his absence or inability, and such deputy shall accept such appointment, in writing, and be subject to the provisions of this article and all rules and regulations governing registrars.

2. When it appears necessary for the convenience of the people in any district, the registrar is authorized, with the approval of the commissioner, to appoint one or more suitable persons to act as subregistrars, who shall be authorized to receive birth and death certificates and to issue burial or removal permits in and for such portions of the district as may be designated, and each such subregistrar shall note on each certificate over his signature the date of filing and shall forward all certificates to the local registrar of the district within three days, and in all cases before the third day of the following month.

§ 4123. Vital statistics; registrars; term of office; oath; removal.

1. Unless the charter of the city or village shall provide otherwise, the term of office of a registrar of vital statistics shall be four years, except that in a town or village of the first class operating under the general town or village law, the term of office of registrar of vital statistics shall be coterminous with the term of office of the town or village clerk, as the case may be. The term of office of a county or part-county registrar shall be coterminous with that of the county commissioner of health or public health director. If there be no county commissioner of health or public health director, then the term of office of such county or part-county registrar shall be as determined by the board of supervisors of such county.

2. Each registrar of vital statistics shall hold office until his successor is appointed and shall have qualified.

3. Any registrar, deputy registrar or subregistrar of vital statistics, who fails or neglects to discharge efficiently the duties of his office in accordance with the provisions of this article or the

regulations of the public health council, or to make prompt and complete returns of births and deaths as required thereby, shall be removed forthwith by the commissioner or by the person or board authorized by law to appoint such registrar, deputy registrar or subregistrar. Such other penalties may be imposed upon him as are provided by this article.

4. Notwithstanding any other provisions of the laws of this state, each registrar, deputy registrar and subregistrar of vital statistics shall file his oath of office with the clerk or clerks of the county or counties in which his registration district is located.

§ 4124. Vital statistics; registrars and subregistrars; compensation and expenses. 1. Except as otherwise provided, each registrar shall be paid:

(a) the sum of fifty cents for each birth certificate properly and completely made out, registered and promptly returned by him to the commissioner as required by this article;

(b) the sum of fifty cents for each death certificate properly and completely made out in accordance with the international classification of diseases and returned and filed with the registrar, and correctly recorded and promptly returned by him to the commissioner, as required by this article;

(c) the sum of fifty cents for each burial, removal or transit permit issued by him;

(d) the sum of fifty cents for each report of fetal death properly and completely made out and filed with the registrar; and

(e) his actual and necessary expenses.

2. A village clerk, unless the charter of the village provides otherwise, or a town clerk serving as registrar of vital statistics shall be entitled to the fees provided in this section. If a city clerk, town clerk or village clerk is appointed a registrar of vital statistics, as authorized by section forty-one hundred twenty-one of this article, all fees collected by such registrar in the discharge of his duties shall be the property of the city, town or village and shall be paid to the chief fiscal officer of such city, town or village,

provided, however, that an amount equivalent to the sum of such fees shall be paid at least monthly by such chief fiscal officer to such city clerk, town clerk or village clerk entitled to receive fees as a registrar of vital statistics.

3. (a) In any city, town or village, the legislative body of the city, town board or board of trustees may provide that the registrar be paid a stipulated daily, monthly, or annual salary instead of the fees provided for by this article.

(b) If a stipulated salary is fixed, all fees collected by the registrar in the discharge of his duties shall be the property of the city, town or village and shall be paid to the chief fiscal officer, supervisor or the village treasurer, as the case may be.

(c) In any city, town or village where the compensation of the registrar is fixed by the legislative body of the city, town board or board of trustees at a stipulated salary, the provisions herein as to the payment of fees or as to the certification by the commissioner shall not apply.

(d) In any city, town or village, the registrar shall keep a true and correct account of all fees received by him or her and report the amount of such fees to the chief fiscal officer of such city, town or village on an annual basis.

4. In any case where a local health officer is appointed as registrar of vital statistics he shall serve as such registrar without additional remuneration therefor.

5. In any case where a director or other person in charge of any state hospital, charitable or penal institution is appointed or acts as registrar of vital statistics of such registration district he shall serve as such registrar without additional remuneration therefor.

6. All amounts payable to the local registrar under the provisions of this article shall be paid by the municipality comprising the registration district, upon certification by the commissioner.

7. Remuneration and expenses of the registrars of districts which have

been divided into two or more primary registration districts shall be paid by the municipality comprising the original district.

8. (a) Remuneration and expenses of registrars of combined districts shall be paid by the municipalities comprising such districts in proportion as each would be required to compensate a separate registrar for its own district, except that when such combined districts coincide with a consolidated health district the remuneration and expenses of the registrar shall be paid by the board of health of such consolidated health district as provided by section three hundred ninety-nine of this chapter.

(b) In any combined district, the governing boards of the municipalities comprising such district; or in a combined district coinciding with a consolidated health district, the board of health thereof; or in a district divided into two or more primary registration districts, the governing board of the municipality comprising the original district, may provide that the registrar or registrars therein be paid a stipulated daily, monthly or annual salary instead of fees provided for by this article.

(c) If a salary is paid as provided in paragraph (b) of this section, all fees collected by the registrar in the discharge of his duties shall be the property of the municipality or municipalities involved and the provisions herein requiring the payment of fees to the registrar or the certification by the commissioner shall not apply.

9. The commissioner shall certify annually to the municipality the number of births and deaths properly registered, with the name of the local registrar and the amount due him at the rate fixed herein.

10. Except as otherwise provided, each subregistrar in counties designated pursuant to this article as primary registration districts shall be paid:

(a) the sum of fifty cents for each birth and death certificate properly and completely made out and received, noted and forwarded to the registrar of the district, as required by this article;

(b) the sum of fifty cents for each burial or removal permit issued by him; and

(c) the sum of fifty cents for each report of fetal death properly and completely made out and filed with the registrar.

11. (a) The board of supervisors of the county in which such primary registration district is located may provide that the subregistrar be paid a stipulated daily, monthly or annual salary instead of the fees provided for by subdivision eleven of this section.

(b) The fees specified to be paid subregistrars under subdivision eleven or, in lieu thereof, the salary provided for by the board of supervisors of the county shall be paid by the county embracing such primary registration district.

TITLE III

REGISTRATION OF BIRTHS

- Section 4130. Births; registration.
4131. Births; registration; foundlings.
4132. Birth certificate; form and content.
4133. Birth certificate; incomplete; duty of registrar.
4134. Birth certificate; unnamed child.
4135. Birth certificate; child born out of wedlock.
- 4135-a. Birth certificate; child born in prison.
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4136. Birth certificate; statement as to blood test.
4137. Births; notice of recording.
4138. Birth certificate; new certificate in case of subsequent marriage of unwed parents; adoption; adjudication of parentage; change of name of registrant or parent; gender transition of registrant or parent.
- 4138-a. Certificate of birth data.
- 4138-b. Birth certificate: foreign adoption.
- 4138-c. Adoption information registry.
- 4138-d. Mutual consent voluntary adoption registry.
- 4138-e. Adoptee's right to a certified copy of his or her birth certificate.

§ 4130. Births; registration. 1. Live birth is defined as the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born.

2. The birth of each child born alive in this state shall be registered within five days after the date of birth by filing with the registrar of the district in which the birth occurred a certificate of such birth, which certificate shall be upon the form prescribed therefor by the commissioner.

3. In each case where a physician or nurse-midwife was in attendance upon the birth, it shall be the duty of such physician or nurse-midwife to file said certificate.

4. In each case where there was no physician or nurse-midwife in attendance upon the birth, it shall be the duty of the father or mother of the child, the householder or owner of the premises where the birth occurred, or the director or person in charge of the public or private institution where the birth occurred, each in the order named, within five days after the date of such birth, to report to the local registrar the fact of such birth and to file said certificate.

5. When a birth occurs in a hospital, the person in charge of such hospital or his designated representative shall obtain the personal data, prepare the certificate, secure the signatures required by the certificate and file it with the registrar. The physician in attendance or a physician acting in his behalf shall certify to the facts of birth and provide the medical information required by the certificate within five days after the birth.

§ 4131. Births; registration; foundlings. 1. The report of the finding

of a child whose parents are unknown, filed by the commissioner of social services or by the city social services officer in accordance with the provisions of subdivision two of section three hundred ninety-eight of the social services law, shall constitute the birth record of such child.

2. The district wherein such child was found shall be considered as the place of birth, and the date of birth shall be that determined by the commissioner of social services or by the city social services officer as the approximate date of birth.

3. If, however, such child be subsequently identified, and it should appear that a certificate of birth for this child has either before or following identification been filed, as otherwise provided in this article, the report of the commissioner of social services or of the city social services officer shall be placed under seal by the state commissioner of health, such seal not to be broken except upon order of a court of competent jurisdiction.

§ 4132. Birth certificate; form and content. 1. The certificate of birth shall contain such information, including the social security numbers of the parents, and be in such form as the commissioner may prescribe.

2. The personal particulars called for shall be obtained from a competent person acquainted with the facts.

3. (a) The certificate shall be signed by the attending physician or nurse-midwife, with date of signature and his or her address.

(b) If there was no physician or nurse-midwife, in attendance, then the certificate of birth shall be signed by the father or mother of the child, householder, owner of the premises, director or other person in charge of the public or private institution where the birth occurred, or by any other competent person whose duty it is to notify the local registrar of such birth.

4. The registrar shall enter the exact date of filing of the certificate of birth in his office attested by his official signature and registered number of birth.

5. Each parent of the child may choose to be designated on the original certificate of birth or by amendment as "father" or "mother" or "parent".

§ 4133. Birth certificate; incomplete; duty of registrar. 1. If a certificate of birth is incomplete, the registrar of the district in which the birth occurred and with whom the certificate has been filed shall immediately notify the person who signed the record, and require him to supply the missing items of information if they can be obtained.

2. In any case where the physician or nurse-midwife in attendance upon the birth of a child within this state, or other person reporting a birth of a child within this state as provided by section four thousand one hundred thirty of this chapter, is unable, by diligent inquiry, to obtain any item or items of information required in this article, it shall then be the duty of the registrar to secure from the person so reporting, or from any other person having the required knowledge, such information as will enable the registrar to prepare the certificate of birth herein required.

3. It shall be the duty of the person reporting such birth or who is interrogated in relation thereto to answer correctly and to the best of his knowledge all questions put to him by the registrar which may be calculated to elicit any information needed to make a complete record of the birth as contemplated by this article, and it shall be the duty of the informant as to any statement made in accordance herewith to verify such statement by his signature, when requested so to do by the registrar.

§ 4134. Birth certificate; unnamed child. 1. If a living child has not yet been named at the date of filing the certificate of birth, the space

provided for the given name of the child is to be left blank, to be filled out subsequently by a supplemental report, as herein provided.

2. If a child dies without a given name, there shall be entered in the space provided for the name the words "died unnamed." The parents of the deceased child may submit a supplemental report of the given name of the deceased child. Such report shall be returned to the local registrar and the given name shall be entered on the original birth certificate.

3. When any certificate of birth of a living child is presented without the statement of the given name, the local registrar shall make out and deliver to the parents of the child a supplemental report of the given name of the child, which shall be filled out as directed, and returned to the local registrar as soon as the child shall have been named. The given name, supplied by the supplemental report, shall be entered on the original birth certificate.

§ 4135. Birth certificate; child born out of wedlock. 1. (a) There shall be no specific statement on the birth certificate as to whether the child is born in wedlock or out of wedlock or as to the marital name or status of the mother.

(b) The phrase "child born out of wedlock" when used in this article, refers to a child whose father is not its mother's husband.

2. The name of the alleged father of a child born out of wedlock shall not be entered on the certificate of birth prior to filing without (i) an acknowledgment of parentage pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of this article executed by both the mother and alleged father, and filed with the record of birth; or (ii) notification having been received by, or proper proof having been filed with, the record of birth by the clerk of a court of competent jurisdiction or the parents, or their attorneys of a judgment, order or decree relating to parentage.

3. Orders relating to parentage shall be held confidential by the commissioner and shall not be released or otherwise divulged except by

order of a court of competent jurisdiction.

§ 4135-a. Birth certificate; child born in prison. There shall be no specific statement on the birth certificate as to the fact that a child was born in prison.

§ 4135-b. Voluntary acknowledgments of parentage. 1. (a) Immediately preceding or following the in-hospital birth of a child to an unmarried person or to a person who gave birth to a child conceived through assisted reproduction, the person in charge of such hospital or his or her designated representative shall provide to the unmarried person who gave birth to the child and the alleged genetic parent, if such alleged genetic parent is readily identifiable and available, or to the person who gave birth and the other intended parent of a child conceived through assisted reproduction if such person is readily identifiable and available, the documents and written instructions necessary for such person or to a person who gave birth to a child conceived through assisted reproduction and alleged persons to complete an acknowledgment of parentage witnessed by two persons not related to the signatory. Such acknowledgment, if signed by both parties, at any time following the birth of a child, shall be filed with the registrar at the same time at which the certificate of live birth is filed, if possible, or anytime thereafter. Nothing herein shall be deemed to require the person in charge of such hospital or his or her designee to seek out or otherwise locate an alleged genetic parent or intended parent of a child conceived through assisted reproduction who is not readily identifiable or available.

(b) The following persons may sign an acknowledgment of parentage to establish the parentage of the child:

(i) An unmarried person who gave birth to the child and another person who is a genetic parent.

(ii) A married or unmarried person who gave birth to the child and another person who is an intended parent under section 581-303 of the family court act of a child conceived through assisted reproduction.

(c) An acknowledgment of parentage shall be in a record signed by the

person who gave birth to the child and by either the genetic parent other than the person who gave birth to the child or a person who is a parent under section 581-303 of the family court act of the child conceived through assisted reproduction.

(d) An acknowledgment of parentage is void if, at the time of signing, any of the following are true:

(i) A person other than the signatories is a presumed parent of the child under section twenty-four of the domestic relations law;

(ii) A court has entered a judgment of parentage of the child;

(iii) Another person has signed a valid acknowledgment of parentage with regard to the child;

(iv) The child has a parent under section 581-303 of the family court act other than the signatories;

(v) A signatory is a gamete donor under section 581-302 of the family court act;

(vi) The acknowledgment is signed by a person who asserts that they are a parent under section 581-303 of the family court act of a child conceived through assisted reproduction, but the child was not conceived through assisted reproduction.

(e) The acknowledgment shall be executed on a form provided by the commissioner developed in consultation with the commissioner of the office of temporary and disability assistance, which shall: (i) include the social security number of the signatories; (ii) provide in plain language (A) a statement by the person who gave birth to the child consenting to the acknowledgment of parentage and a statement that the other signatory is the only possible other genetic parent or that the other signatory is an intended parent and the child was conceived through assisted reproduction, (B) a statement by the, alleged genetic parent, if any, that he or she is the genetic parent of the child, and (C) a statement that the signing of the acknowledgment of parentage by both parties shall have the same force and effect as an order of parentage or filiation entered after a court hearing by a court of competent jurisdiction, including an obligation to provide support for the child except that, only if filed with the registrar of the district in which the birth certificate has been filed, will the acknowledgment have such force and effect with respect to inheritance rights; and (iii) include the name and address, if known, of any gamete donors.

(f) Prior to the execution of an acknowledgment of parentage, the person who gave birth to the child and the other signatory shall be provided orally, which may be through the use of audio or video equipment, and in writing with such information as is required pursuant to this section with respect to their rights and the consequences of signing a voluntary acknowledgment of parentage including, but not limited to:

(i) that the signing of the acknowledgment of parentage shall establish the parentage of the child and shall have the same force and effect as an order of parentage or filiation issued by a court of competent jurisdiction establishing the duty of both parties to provide support for the child;

(ii) that if such an acknowledgment is not made, the signatory other than the person who gave birth to the child can be held liable for support only if the family court, after a hearing, makes an order declaring that the person is the parent of the child whereupon the court may make an order of support which may be retroactive to the birth of the child;

(iii) that if made a respondent in a proceeding to establish parentage the signatory other than the person who gave birth to the child has a right to free legal representation if indigent;

(iv) that an alleged genetic parent has a right to a genetic marker test or to a DNA test when available;

(v) that by executing the acknowledgment, the alleged genetic parent waives their right to a hearing, to which they would otherwise be entitled, on the issue of parentage;

(vi) that a copy of the acknowledgment of parentage shall be filed with the registry created by section three hundred seventy-two-c of the social services law, and that such filing may establish the child's right to inheritance from the alleged genetic parent or the other intended parent of a child conceived through assisted reproduction pursuant to clause (B) of subparagraph two of paragraph (a) of section 4-1.2 of the estates, powers and trusts law;

(vii) that, if such acknowledgment is filed with the registrar of the district in which the birth certificate has been filed, such acknowledgment will establish inheritance rights from the alleged genetic parent or the other intended parent of a child conceived through

assisted reproduction pursuant to clause (A) of subparagraph two of paragraph (a) of section 4-1.2 of the estates, powers and trusts law;

(viii) that no further judicial or administrative proceedings are required to ratify an unchallenged acknowledgment of parentage provided, however, that:

(A) A signatory to an acknowledgment of parentage, who had attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment within the earlier of sixty days from the date of signing the acknowledgment or the date of an administrative or a judicial proceeding (including, but not limited to, a proceeding to establish a support order) relating to the child in which the signatory is a party, provided that the "date of an administrative or a judicial proceeding" shall be the date by which the respondent is required to answer the petition;

(B) A signatory to an acknowledgment of parentage, who had not attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment anytime up to sixty days after the signatory's attaining the age of eighteen years or sixty days after the date on which the respondent is required to answer a petition (including, but not limited to, a petition to establish a support order) relating to the child, whichever is earlier; provided, however, that the signatory must have been advised at such proceeding of his or her right to file a petition to vacate the acknowledgment within sixty days of the date of such proceeding;

(ix) that after the expiration of the time limits set forth in clauses (A) and (B) of subparagraph (viii) of this paragraph, any of the signatories may challenge the acknowledgment of parentage in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof on the party challenging the voluntary acknowledgment;

(x) that the person who gave birth to the child and the other signatory may wish to consult with attorneys before executing the acknowledgment; and that they have the right to seek legal representation and supportive services including counseling regarding such acknowledgment;

(xi) that the acknowledgment of parentage may be the basis for the signatory other than the person who gave birth to the child establishing custody and visitation rights to the child and for requiring the consent

of the signatory other than the person who gave birth to the child prior to an adoption proceeding;

(xii) that the refusal of the person who gave birth to the child to sign the acknowledgment shall not be deemed a failure to cooperate in establishing parentage of the child; and

(xiii) that the child may bear the last name of either parent, or any combination thereof, which name shall not affect the legal status of the child.

In addition, the governing body of such hospital shall ensure that appropriate staff shall provide to the person who gave birth to the child and the other signatory, prior to the discharge from the hospital of the person who gave birth to the child, the opportunity to speak with hospital staff to obtain clarifying information and answers to their questions about parentage establishment, and shall also provide the telephone number of the local support collection unit.

(g) Within ten days after receiving the certificate of birth, the registrar shall furnish without charge to each parent or guardian of the child or to the person who gave birth at the address designated by her for that purpose, a certified copy of the certificate of birth and, if applicable, a certified copy of the written acknowledgment of parentage. If the person who gave birth is in receipt of child support enforcement services pursuant to title six-A of article three of the social services law, the registrar also shall furnish without charge a certified copy of the certificate of birth and, if applicable, a certified copy of the written acknowledgment of parentage to the social services district of the county within which the person who gave birth resides.

2. (a) When a child's parentage is acknowledged voluntarily pursuant to section one hundred eleven-k of the social services law, the social services official shall file the executed acknowledgment with the registrar of the district in which the birth occurred and in which the birth certificate has been filed.

(b) Where a child's parentage has not been acknowledged voluntarily pursuant to paragraph (a) of subdivision one of this section or paragraph (a) of this subdivision, the person who gave birth to the child and the other signatory may voluntarily acknowledge a child's parentage pursuant to this paragraph by signing the acknowledgment of

parentage.

(c) A signatory to an acknowledgment of parentage, who has attained the age of eighteen at the time of execution of the acknowledgment shall have the right to rescind the acknowledgment within the earlier of sixty days from the date of signing the acknowledgment or the date of an administrative or a judicial proceeding (including, but not limited to, a proceeding to establish a support order) relating to the child in which either signatory is a party; provided that for purposes of this section, the "date of an administrative or a judicial proceeding" shall be the date by which the respondent is required to answer the petition.

(d) A signatory to an acknowledgment of parentage, who has not attained the age of eighteen at the time of execution of the acknowledgment, shall have the right to rescind the acknowledgment anytime up to sixty days after the signatory's attaining the age of eighteen years or sixty days after the date on which the respondent is required to answer a petition (including, but not limited to, a petition to establish a support order) relating to the child in which the signatory is a party, whichever is earlier; provided, however, that the signatory must have been advised at such proceeding of his or her right to file a petition to vacate the acknowledgment within sixty days of the date of such proceeding.

(e) After the expiration of the time limits set forth in paragraphs (c) and (d) of this subdivision, any of the signatories may challenge the acknowledgment of parentage in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof on the party challenging the voluntary acknowledgment. The acknowledgment shall have full force and effect once so signed. The original or a copy of the acknowledgment shall be filed with the registrar of the district in which the birth certificate has been filed.

3. (a) An acknowledgment of parentage executed by any two people eligible to sign such an acknowledgment under paragraph (b) of subdivision one of this section, married or unmarried, shall establish the parentage of a child and shall have the same force and effect as an order of parentage or filiation issued by a court of competent jurisdiction. Such acknowledgement shall thereafter be filed with the registrar pursuant to subdivision one or two of this section.

(b) A registrar with whom an acknowledgment of parentage has been filed pursuant to subdivision one or two of this section shall file the acknowledgment with the state department of health, the New York city department of health and mental hygiene and the registry operated by the department of social services pursuant to section three hundred seventy-two-c of the social services law. If the acknowledgment includes the name and address of any known gamete donors of a child conceived through assisted reproduction, the state department of health or the New York city department of health and mental hygiene shall mail a copy to the known donors listed on the form with the social security numbers of the signatories redacted.

4. The court shall give full faith and credit to an acknowledgment of parentage effective in another state if the acknowledgment was in a signed record and otherwise complies with the law of the other state.

5. A new certificate of birth shall be issued if the certificate of birth of the child as defined in paragraph (b) of subdivision one of section four thousand one hundred thirty-five of this article has been filed without entry of the name of the signatory other than the person who gave birth, and the commissioner thereafter receives a notarized acknowledgment of parentage accompanied by the written consent of the person who gave birth to the child and other signatory to the entry of the name of such person, which consent may also be to a change in the surname of the child.

6. Any reference to an acknowledgment of paternity in any law of this state shall be interpreted to mean an acknowledgment of parentage signed pursuant to this section or signed in another state consistent with the law of that state.

§ 4136. Birth certificate; statement as to blood test. 1. In reporting every birth and fetal death, physicians and others permitted to attend pregnancy cases and required to report births and fetal deaths shall state on the birth certificate or fetal death certificate, as the case may be, whether a blood test for syphilis has been made during such

pregnancy upon a specimen of blood taken from the woman who bore the child for which a birth or fetal death certificate is filed.

2. In addition to the information provided to be contained in each certificate of birth by this article every certificate of birth shall state whether such test was made during pregnancy or at delivery, and in the case where no blood test has been made such fact shall be reported together with the reason why such test has not been taken in compliance with the provisions of section two thousand three hundred eight of this chapter.

3. If such test has been made during pregnancy, those required to report births and fetal deaths shall state the date on which the test was made.

4. In no event shall the birth certificate state the result of the blood test.

§ 4137. Births; notice of recording. 1. (a) Within ten days after receiving the certificate of birth the registrar shall furnish without charge to the parents or guardian of the child or to the mother at the address designated by her for the purpose, a certified copy.

(b) The registrar shall, at the same time, furnish without charge to the parents or guardian of the child or to the mother at the address designated by her the immunization schedule for children. The registrar shall include the telephone number of the local county health department on the immunization schedule.

2. A certificate of registration of birth shall be accepted by public authorities in this state for the purposes indicated in section four thousand one hundred three of this chapter in the same manner as certified copies or certified transcripts of birth certificates.

3. The local registrar shall also make a notation on his copy of the original birth certificate indicating the date of issuance of such certified copy.

§ 4138. Birth certificate; new certificate in case of subsequent marriage of unwed parents; adoption; adjudication of parentage; change of name of registrant or parent; gender transition of registrant or parent. 1. A new certificate of birth shall be made whenever:

(a) proof is submitted to the commissioner that the previously unwed parents of a person have intermarried subsequent to the birth of such person; or,

(b) notification is received by, or proper proof is submitted to, the commissioner from or by the clerk of a court of competent jurisdiction or the parents, or their attorneys, or the person himself, of a judgment, order or decree relating to the parentage; or,

(c) notification is received by, or proper proof is submitted to, the commissioner from or by the clerk as aforesaid of a judgment, order or decree relating to the adoption of such person. Such judgment, order or decree shall also be sufficient authority to make a new birth certificate with conforming change in the name of such person on the birth certificate of any of such person's children under the age of eighteen years whose record of birth is on file in the state health department; or,

(d) proper proof is submitted to the commissioner by the parents, or their attorneys, or the person himself or his attorney, of a judgment, order or decree relating to a change of name granted by a court of competent jurisdiction. Such judgment, order or decree shall also be sufficient authority to make a new birth certificate with conforming change in surname for any of such person's children under the age of eighteen years whose record of birth is on file in the state health department; or,

(e) the certificate of birth of a child born out of wedlock as defined in paragraph (b) of subdivision one of section four thousand one hundred thirty-five of this article has been filed without entry of the name of the signatory other than the person who gave birth and the commissioner thereafter receives the acknowledgment of parentage pursuant to section one hundred eleven-k of the social services law or section four thousand one hundred thirty-five-b of this article executed by the person who gave birth and the other signatory which authorizes the entry of the

name of such other signatory, and which may also authorize a conforming change in the surname of the child; or

(f) any person born in New York state who submits an application to change the gender on the birth certificate and an affidavit attesting under penalty of perjury that the request for a change of gender to (female, male, or X) is to conform the person's documents and records to the person's gender identity and is not made for any fraudulent purpose. A sex designation of X shall not be a required sex designation of any individual. Upon receipt of the documentation, the commissioner shall establish a new birth certificate reflecting the gender stated in the application and any change in name, if accompanied by a court order for a change of name. If such application is made on behalf of a person younger than seventeen, such affidavit shall be signed by the person's parent, legal guardian, mental health or medical provider, or social services provider.

2. (a) On every new certificate of birth made pursuant to this section, a notation that it is filed pursuant to section four thousand one hundred thirty-eight of the public health law shall be entered thereon. Notwithstanding other provisions of this article, when a child is adopted by an unmarried man or woman, the new certificate shall, if the adopting parent so requests, reflect the fact that it is a single parent adoption.

(b) Notwithstanding other provisions of this article, when a petition for adoption by two persons has been duly filed, and one of the petitioners dies before the adoption is complete, such deceased petitioner's name shall be included on the new certificate as a parent, if such adoption is completed, unless otherwise requested by the other petitioner.

(c) If the original certificate of birth contains fictitious names of either or both parents, a new certificate shall not be prepared until notification is received by, or proper proof is submitted to, the commissioner by the clerk of a court of competent jurisdiction or the parents or their attorney, or the person himself, or his attorney, of a judgment, order or decree relating to parentage.

3. (a) When a new certificate of birth is made the commissioner shall

substitute such new certificate for the certificate of birth then on file, if any, and shall send the registrar of the district in which the birth occurred a copy of the new certificate of birth. The registrar shall make a copy of the new certificate for the local record and hold the contents of the original local record confidential along with all papers and copies pertaining thereto. It shall not be released or otherwise divulged except by order of a court of competent jurisdiction or pursuant to section four thousand one hundred thirty-eight-e of this title.

(b) Thereafter, when a verified transcript or certification of birth of such person is issued by the registrar, it shall be based upon the new certificate, except when an order of a court of competent jurisdiction shall require the issuance of a verified transcript or certification based upon the original local record of birth or application is made pursuant to section four thousand one hundred thirty-eight-e of this title.

4. The commissioner may make a microfilm or other suitable copy of the original certificate of birth and all papers pertaining to the new certificate of birth. In such event, the original certificate and papers may be destroyed. All undestroyed certificates and papers and copies thereof shall be confidential and the contents thereof shall not be released or otherwise divulged except by order of a court of competent jurisdiction or pursuant to section forty-one hundred thirty-eight-c, forty-one hundred thirty-eight-d or forty-one hundred thirty-eight-e of this title.

5. Thereafter, when a certified copy or certified transcript of the certificate of birth of such a person, or a certification of birth for such person is issued, it shall be based upon the new certificate of birth, except when an order of a court of competent jurisdiction shall require the issuance of a copy of the original certificate of birth or application is made pursuant to section four thousand one hundred thirty-eight-e of this title.

6. When the commissioner shall receive proper proof or notification pursuant to paragraphs (a), (b), or (c) of subdivision one of this

section relating to a person born outside this state, such proof or notification shall be forwarded to the appropriate registration authority for the place of birth.

7. Whenever the commissioner makes a new birth certificate for any person pursuant to the provisions of subdivision one of this section, he shall forward to such person, if eighteen years of age or more, or to the parents of such person, a certified copy, a certified transcript or a certification of birth, whichever he deems appropriate under the circumstances, without making any charge therefor.

8. An adopted person eighteen years of age or older, or the birth parent or parents, may submit to the registrar a notice of change of name and/or address and such information shall be attached to the original birth certificate of the adopted person.

§ 4138-a. Certificate of birth data. Any existing certificate of birth data shall continue to be effective.

§ 4138-b. Birth certificate: foreign adoption. 1. Whenever the finalization of a foreign adoption or recognition of a foreign adoption of a person of any age pursuant to section one hundred eleven-c of the domestic relations law, or the adoption of a foreign-born person of any age at the time of adoption has been reported to the commissioner, the commissioner shall file a birth certificate for the adopted person provided there is no other birth certificate or other birth record on file other than in the country where such person was born and provided, further, that a certificate of birth data does not exist for that person. Such birth certificate shall be filed upon receipt of: proof that the adoptive parent was a resident of this state at the time of adoption or that the adoptee was lawfully adopted within the State of New York; if the adoptee was adopted in a foreign country or jurisdiction, a copy of the adoption documents of the jurisdiction or country in which the person was adopted; a certified translation of the foreign adoption documents, evidence of the date and place of the

adopted person's birth; and evidence of IR-3, IR-4 or IH-3 immigrant visa status or a successor immigrant visa status. The birth certificate shall include the adopted person's name, sex, date of birth, time of birth, place of birth, mother's maiden name, and father's name. A birth certificate issued pursuant to this section which has been filed by a local registrar and all supporting documentation shall be submitted by the local registrar to the commissioner who shall file a new birth certificate pursuant to this section.

2. A petitioner may submit an attorney certified copy of the adoptee's foreign birth certificate, or similar confirmation of birth, and adoption decree, and copies of attorney certified translations of the foreign documentation in connection with the finalization of a foreign adoption or recognition of a foreign adoption pursuant to section one hundred eleven-c of the domestic relations law.

3. This provision shall be deemed retroactive so that an adopted person who was adopted in accordance with this section prior to the effective date hereof may obtain, upon application, a birth certificate pursuant to this section.

§ 4138-c. Adoption information registry. 1. There shall be established in the department an adoption information registry operated by employees of the department specifically designated by the commissioner. Access to all records and information in the registry shall be limited to such designated employees and such records and information shall be kept strictly confidential except as specifically authorized by law. The commissioner shall establish rules and procedures designed to keep such records and information separate and apart from other records of the department and kept in a manner where access to such records and information is strictly limited to such designated employees and shall promulgate regulations designed to effectuate the purposes of this section. Notwithstanding any inconsistent provision of the domestic relations law or any other law to the contrary, the commissioner shall have access to the information authorized to be released pursuant to this section contained in birth and adoption records of any agency,

court or department having appropriate records which will enable the commissioner to effectuate the purposes of this section and may require the cooperation of such agency, court or department in providing the information authorized to be released pursuant to this section, provided, however, that the commissioner shall not have access to the actual adoption records of any agency, court or department maintaining such records.

1-a. For the purposes of this section, "adoptee" shall include: those persons born in this state, and those persons born in any other state within the United States or in the District of Columbia whose adoption occurred within this state.

2. Upon application for registration by an adoptee not born in this state, or by a birth parent or biological sibling of such an adoptee, the department shall, to the extent practicable, determine whether the adoptee's adoption occurred within this state. If the department determines that the adoption occurred within this state, it shall register the applicant if he or she is otherwise qualified and make appropriate notifications pursuant to subdivision four of this section. The registry shall accept, at any time, and maintain the verified registration transmitted by an agency pursuant to section forty-one hundred thirty-eight-d of this title, or of the birth parents of an adoptee who was born in this state. The registry shall neither accept nor maintain the registration of an adoptee sooner than eighteen years after the adoptee's birth, or in the case of registration by a biological sibling of an adoptee, no sooner than the longer of eighteen years after the biological sibling's birth or eighteen years after the adoptee's birth. Any person whose registration was accepted may withdraw such registration prior to the release of any identifying information. The adoptee registrant, and the biological sibling registrant, shall include as part of the registration the identification, including the name and address, of known biological siblings of the adoptee. The adoptee may upon registration, or any time thereafter, elect not to have release of information by the authorized agency involved in such adoption. The department shall establish an authorized agency fee schedule for search costs and registry costs and services provided by

such agency in gathering and forwarding information pursuant to this section. The fee schedule may also include costs for disseminating information about the registry and the adoption medical information sub-registry to the public. Such publications or brochures may include information as to identifying and non-identifying information, how to register and fees charged to the registrants, and any other information deemed appropriate.

3. For the purposes of this section, the term "non-identifying information" shall only include the following information, if known, concerning the adoptee, parents and biological siblings of an adoptee:

- (a) Age of the parents in years, at birth of such adoptee.
- (b) Heritage of the parents, which shall include nationality, ethnic background and race.
- (c) Education, which shall be the number of years of school completed by the parents at the time of birth of such adoptee.
- (d) General physical appearance of the parents at the time of the birth of such adoptee, which shall include height, weight, color of hair, eyes, skin and other information of similar nature.
- (e) Religion of parents.
- (f) Occupation of parents.
- (g) Health history of parents.
- (h) Talents, hobbies and special interests of parents.
- (i) Facts and circumstances relating to the nature and cause of the adoption.
- (j) Name of the authorized agency involved in such adoption.
- (k) The existence of any known biological siblings.
- (l) The number, sex and age, at the time of the adoptee's adoption, of any known biological siblings.

4. Upon acceptance of a registration of an adoptee born in this state, or by a birth parent or biological sibling of such adoptee, pursuant to this section, the department shall search the records of the department to determine whether the adoptee's adoption occurred within this state. After making a determination, to the extent practicable, as to whether an adoptee's adoption occurred within this state pursuant to subdivision two of this section, or upon completing a search of the records pursuant

to this subdivision:

(a) If the department determines that the adoption occurred within this state, it shall notify the court wherein the adoption occurred to submit to the department non-identifying information as may be contained in the records of the court and the names of the birth parents of the adoptee. Notwithstanding any other provision of law to the contrary, the court shall thereupon transmit to the department non-identifying information as may be contained in the records of the court, and the names of the birth parents of the adoptee, provided that, if the court determines from its records that the adoption was from an authorized agency, the court shall submit to the department only the name and address of such authorized agency and the names of the birth parents of the adoptee. In such cases, unless the adoptee registrant shall have elected otherwise, the department shall notify the authorized agency whose name was provided by the court to release promptly to the adoptee all non-identifying information as may be contained in the agency records. Such agency shall thereafter promptly release the non-identifying information to the adoptee registrant. If the adoptee registrant shall have elected not to have the information released to him or her by the authorized agency, the agency shall submit promptly to the department all non-identifying information as may be contained in the agency records. In any case where the agency records are incomplete, no longer exist or are otherwise unavailable, the department shall so notify the court. The court shall thereupon promptly submit such non-identifying information as may be contained in their records. If no authorized agency was involved or if the adoptee registrant shall have elected not to have release of information by the authorized agency involved in such adoption, the department shall release the non-identifying information to the adoptee registrant. The department and/or an authorized agency may restrict the nature of the non-identifying information released pursuant to this section upon a reasonable determination that disclosure of such non-identifying information would not be in the adoptee's, biological sibling's, or parent's best interest.

(b) If the department determines that the adoption did not occur within the state, it shall notify the adoptee registrant that no record exists of the adoption occurring within the state.

5. Upon acceptance of a registration pursuant to this section, the department shall search the registry to determine whether the adoptee, any biological sibling of the adoptee, or birth parents of the adoptee is also registered.

(a) If the department determines the adoptee is not in contact with a biological sibling under the age of eighteen and that there is a corresponding registration for the adoptee, for either of the birth parents, and/or for the biological sibling registrant, it shall notify the court wherein the adoption occurred and the department shall notify all such persons that a corresponding match has been made and request such persons' final consent to the release of identifying information.

(b) If the department determines that there is no corresponding registration for the adoptee, for either of the birth parents, and/or for a biological sibling of the adoptee, it shall notify the registering person that no corresponding match has been made. The department shall not solicit or request the consent of the non-registered person or persons.

6. Upon receipt of a final consent by the adoptee, by either of the birth parents, and/or by a biological sibling of the adoptee, the department shall, unless the adoptee or biological sibling registrant shall elect otherwise, if an authorized agency was involved in such adoption, release identifying information to such agency; such agency shall thereafter promptly release identifying information about the consenting registrants to the consenting registrants. If no authorized agency was involved, or if any registrant shall have elected not to have release of the information by the authorized agency involved in such adoption the department shall release identifying information to the consenting registrants. Such identifying information shall be limited to the names and addresses of the consenting registrants and shall not include any other information contained in the adoption or birth records. However, nothing in this section shall be construed to prevent the release of adoption records as otherwise permitted by law.

6-a. (a) There shall be established in the registry an adoption medical information sub-registry. Access to all identifying records and

information in the sub-registry shall be subject to the same restrictions as the adoption information registry.

(b) The department shall establish procedures by which a birth parent may provide medical information to the sub-registry, and by which an adoptee aged eighteen years or older or the adoptive parents of an adoptee who has not attained the age of eighteen years may access such medical information.

(c) A birth parent may provide the adoption medical information sub-registry with certified medical information. Such certified medical information must include other information sufficient to locate the adoptee's birth record.

(d) Upon receipt from the birth parent of certified medical information and other information needed to identify the adopted person, the department shall, to the extent practicable, determine if the adoptee was adopted in New York state. If the adoptee was adopted in New York state, the department shall register such information and determine if the adoptee or adoptive parent of the adoptee is registered. Upon such determination, the department shall release the non-identifying medical information only to an adoptee, aged eighteen years or older, or adoptive parent of an adoptee who has not attained the age of eighteen years.

(e) Upon receipt from an adoptee aged eighteen years or older or the parent of an adoptee of a registration, the department shall, to the extent practicable, determine if the adoptee was adopted in New York state. If the adoptee was adopted in New York state, the department shall search its records for medical information provided by the adoptee's birth parent. If such medical information is found, the department shall release the non-identifying medical information only, to an adoptee, aged eighteen years or older, or adoptive parent of an adoptee who has not attained the age of eighteen years.

(f) The department shall not solicit or request the provision of medical information from a birth parent or the registration by an adoptee or parent of an adoptee.

(g) A fee shall not be required from a birth parent for providing health information.

7. (a) Any employee of the department or any employee of an authorized

agency who solicits or causes another to solicit a registration for the purposes of this section, except as otherwise permitted by law, shall be guilty of a misdemeanor, provided, however, that solicitation shall not include disclosure of the adoption information registry.

(b) Any person who unlawfully discloses any information in the adoption information registry shall be guilty of a class A misdemeanor.

(c) Notwithstanding any other provision, any employee of the department who unlawfully discloses any information in the adoption information registry shall be subject to dismissal for such violation.

8. For purposes of this section: "authorized agency" or "agency" means an authorized agency as defined in paragraphs (a) and (b) of subdivision ten of section three hundred seventy-one of the social services law.

10. The commissioner is directed to develop an adoption information registry birth parent registration consent form to be completed at the time of surrender or consent to adoption. Such form shall include check-off boxes to be appropriately marked by the biological parent or parents whose consent is necessary for the relinquishment of such child indicating whether or not such parent consents to the receipt of identifying information by the child to be adopted. A copy of such form shall be sent to the department with copies of the original and amended birth certificates. Such form shall state that it is the responsibility of the birth parent to update the registry with any changes in contact information. The form shall additionally advise the biological parents of the adoption medical information sub-registry and the procedures by which a birth parent may provide medical information to the sub-registry. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is directed to develop any rules and regulations necessary to expedite the transfer of information from any agency, court or department necessary to implement this subdivision.

11. Upon receipt of the adoption information registry birth parent registration consent form required by section two hundred fifty-four of the judiciary law, the commissioner of health of the city of New York shall forward a copy of such consent form, copies of the original birth certificate, the amended birth certificate and a copy of the

notification of adoption to the adoption information registry maintained in accordance with this section.

§ 4138-d. Mutual consent voluntary adoption registry. 1. A mutual consent voluntary adoption registry may be established and maintained by each authorized agency involved in an adoption. Persons eligible to receive identifying information may work through the agency involved in the adoption. If that agency has merged or ceased operations, a successor agency which has the files pertaining to adoptions in which the ceased or merged agency was involved may establish and maintain a mutual consent voluntary adoption registry concerning those adoptions. Any authorized agency which establishes and maintains a mutual consent voluntary adoption registry pursuant to this section shall notify the department of the name and address of such agency, together with such other information the department may require.

2. The agency shall accept, at any time, and maintain the verified registration of the birth parents of an adoptee. The agency shall accept and maintain the verified registration of an adoptee or of the biological sibling of an adoptee if such adoptee was born in this state, or was born in any other state within the United States, or in the District of Columbia, and his or her adoption occurred within this state, no sooner than eighteen years after the adoptee's birth or in the case of a biological sibling registrant, no sooner than the longer of eighteen years after the birth of the adoptee or eighteen years after the birth of the biological sibling; provided however, that any person whose registration was accepted may withdraw such registration prior to the release of any identifying information.

3. Upon acceptance of a registration pursuant to this section, the agency shall search the records of the agency to determine whether the agency was involved in such adoption.

(a) If the agency determines that the agency was not involved in such adoption, it shall notify the registrant that no record exists of the adoption and refer the registrant to the department's adoption information registry operated pursuant to section forty-one hundred

thirty-eight-c of this title.

(b) If the agency determines that the agency was involved in such adoption, it shall transmit the registration to the adoption information registry operated by the department and the agency shall release the non-identifying information, as defined in section forty-one hundred thirty-eight-c of this title, to the adopted person.

4. Upon acceptance of a registration pursuant to this section, the department shall search the records of the department to determine whether the adoptee's adoption occurred within the state. The department shall establish an authorized agency fee schedule for search costs and registry costs of an authorized agency.

(a) If the department determines that there is a corresponding registration for the adoptee, for either of the birth parents and/or for a biological sibling of the adoptee, it shall notify the court wherein the adoption occurred and the department shall notify the agency that a corresponding match has been made. The agency shall notify all such registrants that a corresponding match has been made and request such persons' final consent to the release of identifying information.

(b) If the department determines that there is no corresponding registration for the adoptee, for either of the birth parents and/or for a biological sibling of the adoptee, it shall notify the agency which shall notify the registering person that no corresponding match has been made. The agency shall not solicit or request the consent of the non-registered person or persons.

5. Upon receipt of a final consent by the adoptee, by either of the birth parents and/or by a biological sibling of the adoptee, the agency shall release identifying information about the consenting registrants to the consenting registrants. Such identifying information shall be limited to the names and addresses of the consenting registrants and shall not include any other information contained in the adoption or birth records. However, nothing in this section shall be construed to prevent the release of adoption records as otherwise permitted by law.

6. (a) Any employee of the agency who solicits or causes another to solicit a registration for the purposes of this section, except as

otherwise permitted by law, shall be guilty of a misdemeanor, provided, however, that solicitation shall not include disclosure of the existence of the adoption information registry.

(b) Any person who unlawfully discloses any information in the mutual consent voluntary adoption registry shall be guilty of a class A misdemeanor.

(c) Notwithstanding any other provision, any employee of the department who unlawfully discloses any information in the mutual consent voluntary adoption registry shall be subject to dismissal for such violation.

7. Upon receipt of identifying information from the department pursuant to section four thousand one hundred thirty-eight-c of this article, the agency shall promptly release identifying information to all the registrants. Such identifying information shall be limited to the names and addresses of the registrants and shall not include any other information contained in the adoption or birth records or other records maintained by the agency. However, nothing in this section shall be construed to prevent the release of adoption records as otherwise permitted by law.

8. For purposes of this section: "authorized agency" or "agency" means an authorized agency as defined in paragraphs (a) and (b) of subdivision ten of section three hundred seventy-one of the social services law.

§ 4138-e. Adoptee's right to a certified copy of his or her birth certificate. 1. The legislature hereby states its intention to acknowledge, support and encourage the life-long health and well-being needs of persons who have been and will be adopted in this state. The legislature further recognizes that the denial of access to accurate and complete medical and self-identifying data of any adopted person, known and wilfully withheld by others, may result in such person succumbing to preventable disease, premature death or otherwise unhealthy life, is a violation of that person's human rights and is contrary to the tenets of government. As such, the provisions of this section seek to establish considerations under the law for adopted persons equal to such

considerations permitted by law to all non-adopted persons; this section does so while providing for the privacy of an adopted person and his or her birth.

2. (a) Notwithstanding any other provision of law, the commissioner or a local registrar or any person authorized by the commissioner or a local registrar, upon application, proof of identity and payment of a nominal fee, shall issue certified copies of original long form line by line, vault copy birth certificates, including any change attached to that certificate by a birth parent or parents, and any information provided to the commissioner or a local registrar pursuant to subdivision one of section one hundred fourteen of the domestic relations law, to (i) an adopted person, if eighteen years of age or more, or (ii) if the adopted person is deceased, the adopted person's direct line descendants, or (iii) the lawful representatives of such adopted person, or lawful representatives of such deceased adopted person's direct line descendants, as the case may be.

(b) When it shall be impossible for the commissioner or a local registrar to provide a copy of an adult adopted person's original long form birth certificate (as may occur in the case of an adopted person born outside of, but adopted within, the state and such certificate is not part of the records of the commissioner or a local registrar), the true and correct information about the adopted person and the adopted person's birth parents, including their identifying information, that would have appeared on such original birth certificate shall be provided to: (i) the adopted person, if eighteen years of age or more, or (ii) if the adopted person is deceased, the adopted person's direct line descendants, or (iii) the lawful representatives of such adopted person, or lawful representatives of such deceased adopted person's direct line descendants, as the case may be by any authorized agency as defined in paragraphs (a) and (b) of subdivision ten of section three hundred seventy-one of the social services law. In such case, the agency shall be held harmless from any liability arising out of the disclosure.

(c) For purposes of this subdivision, the term "commissioner" shall include the state commissioner of health, the commissioner of health and mental hygiene of the city of New York and for records of birth prior to January first, nineteen hundred fourteen, the local registrars of the

cities of Albany, Buffalo and Yonkers.

TITLE III-A

FILING OF CERTIFICATES OF DISSOLUTION OF MARRIAGE

Section 4139. Certificates of dissolution of marriages to be filed with the department; duties of county clerks in connection therewith.

§ 4139. Certificates of dissolution of marriages to be filed with the department; duties of county clerks in connection therewith. 1. No interlocutory decree, judgment or order of divorce, annulment, or other dissolution of marriage shall hereafter be filed or entered in the office of any county clerk of this state, unless there is submitted therewith, a certificate of dissolution of marriage on a form prescribed, printed and furnished by the commissioner. Such form may contain a confidential section for statistical and research purposes. Such section shall not be subject to subpoena or to inspection by persons other than the commissioner or authorized personnel of the department. The commissioner may, however, pursuant to appropriate rules assuring that the identity of individuals will not be revealed, approve the inspection and use of such confidential sections for scientific purposes.

2. Such certificate shall contain the names and addresses of the attorneys for the parties thereto, the names, social security numbers and addresses of the parties to the action, and such other information as prescribed by the commissioner, including but not limited to such information as may be requested by the federal agency in charge of vital statistics.

3. At such times as the commissioner shall direct, the county clerk of each county shall transmit to the department the certificates of dissolution of marriage so filed in his office for each case where the decree became final during the previous months. Such certificates of dissolution of marriage shall be kept on file and properly indexed by

the department.

4. A certified copy or certified transcript of such certificate may be furnished to either party to the action by the commissioner. A certified copy or certified transcript of such certificate may be furnished by the commissioner to one other than a party to the action, only upon order of a judge of a court of record, or a judge of a family court, granted upon application of such other person, with or without notice, upon showing a proper or judicial necessity therefor, which order and the papers accompanying same shall be filed by the commissioner and given the indexed number of the certificate of dissolution to which it relates. The commissioner shall be deemed to have complied with the applicable provisions of this subdivision by the issuance of a certified transcript of the desired certificate instead of a certified copy thereof except where the requester shall show, to the satisfaction of the commissioner or his designated representative, a demonstrated need for such certified copy, or where a court order rendered pursuant to the provisions of this subdivision contains an express recital or direction therein that the issuance of a certified transcript of such certificate instead of a certified copy thereof shall not be considered to be in compliance therewith.

5. Whenever in his opinion, information as to the dissolution of a marriage is required for a legal or other proper purpose, the commissioner may make a search of the files and, if the record of dissolution of marriage is found, he may furnish to the applicant, in the form of a certification, the names of the parties to the dissolved marriage, the name of the county and county seat of such county in which the decree dissolving the marriage was granted, and the date the decree was entered.

6. The commissioner shall be entitled to a fee of thirty dollars for each certification, certified copy or certified transcript of certificate of dissolution of marriage furnished.

7. For a search of the files where no such certification, certified copy, or certified transcript is furnished, or for a certification that

a search discloses no record of a dissolution of marriage, the commissioner shall be entitled to a fee of thirty dollars.

8. Notwithstanding any other provisions of this section, the federal agency in charge of vital statistics may obtain from the department at a fee acceptable to the commissioner, information from certificates of dissolution of marriage for use solely as statistical data without the order of a justice of the supreme court. For other official purposes, subject to the provisions of subdivision four of this section, certifications, certified copies, or certified transcripts of certificates of dissolution of marriage may be furnished, at a fee acceptable to the commissioner upon specific request therefor by a department of the state of New York or of the government of the United States.

TITLE IV

REGISTRATION OF DEATHS: BURIAL PERMITS

- Section 4140. Deaths from natural causes; registration.
- 4141. Death certificate; form and content.
 - 4141-a. Death certificate; duties of hospital administrator.
 - 4142. Death certificate; duties of funeral director.
 - 4143. Deaths without medical attendance; registration.
 - 4144. Deaths; burial and removal permits; transportation of remains.
 - 4145. Deaths; burial and removal permits; disposition of remains.
 - 4146. Deaths; burial permits; interments in certain cemeteries prohibited.
 - 4147. Deaths; confidentiality of records.
 - 4148. Electronic death registration system.

§ 4140. Deaths; registration. 1. The death of each person who has died in this state shall be registered immediately and not later than seventy-two hours after death or the finding of a dead human body, by filing with the registrar of the district in which the death occurred or

the body was found a certificate of such death, in a manner and format as prescribed by the commissioner, which shall include through electronic means in accordance with section forty-one hundred forty-eight of this title.

2. If the certificate of death is properly executed and complete, the registrar of the district in which the death occurred shall then issue a burial or removal permit to the funeral director or undertaker. In case the death occurred from a disease which is designated in the sanitary code as a communicable disease, no permit for the removal or other disposition of the body shall be issued by the registrar, except to a funeral director or undertaker licensed in accordance with the provisions of this chapter, under such conditions as may be prescribed in the sanitary code.

3. The commissioner and the department of health of the city of New York shall deliver to the state board of elections, at least monthly, records in a format as mutually determined by both agencies, of the names of all persons of voting age for whom death certificates were issued. Such records shall be arranged by county of residence and shall include the name, residence address and birth date of each such person.

§ 4141. Death certificate; form and content. 1. The certificate of death shall contain such information, including but not limited to the decedent's social security number, and shall be in such form as the commissioner may prescribe.

2. The personal particulars called for shall be furnished by a competent person acquainted with the facts.

3. The statement of facts relating to the disposition of the body shall be signed by the funeral director or undertaker in charge of the corpse.

4. (a) The medical certificate shall be made, dated, and signed by the physician or nurse practitioner, if any, last in attendance on the

deceased.

(b) Indefinite terms, denoting only symptoms of disease or conditions resulting from disease, shall not be held sufficient.

(c) Any certificate stating the cause of death in terms which the commissioner declares indefinite shall be returned to the physician, nurse practitioner, or person making the medical certificate for correction and more definite statement.

(d) Where a death is caused by an opioid overdose, such information shall be indicated on the certificate, including, if known to the person completing the death certificate, the specific opioid that caused the death of the decedent, along with any other related information as the commissioner may require.

§ 4141-a. Death certificate; duties of hospital administrator. When a death occurs in a hospital, except in those cases where certificates are issued by coroners or medical examiners, the person in charge of such hospital or his or her designated representative shall promptly present the certificate to the physician or nurse practitioner in attendance, or a physician or nurse practitioner acting in his or her behalf, who shall promptly certify to the facts of death, provide the medical information required by the certificate, sign the medical certificate of death, and thereupon return such certificate to such person, so that the seventy-two hour registration time limit prescribed in section four thousand one hundred forty of this title can be met; provided, however that commencing on or after the implementation date under section forty-one hundred forty-eight of this title, information and signatures required by this section shall be obtained and made in accordance with section forty-one hundred forty-eight of this title.

§ 4142. Death certificate; duties of funeral director. In each case the funeral director, undertaker or person having charge of the body of a deceased person, shall:

(a) obtain the personal and statistical particulars required for the certificate of death from a competent person acquainted with the facts and qualified to supply them and enter them on the certificate together

with the name and address of his informant;

(b) present the certificate promptly to the attending physician or nurse practitioner, who shall forthwith certify to the facts of death, provide the medical information required by the certificate and sign the medical certificate of death, or to the coroner or medical examiner in those cases where so required by this article or, when a death occurs in a hospital, except in those cases where certificates are issued by coroners or medical examiners, to the person in charge of such hospital or his or her designated representative, who shall obtain the medical certificate of death as prescribed in section four thousand one hundred forty-one-a of this title;

(c) state the facts required on the certificate of death relative to the date and place of burial, cremation or removal, over his signature and with his address; and,

(d) prior to the disposition of the remains, file the certificate of death with the registrar of the district in which the death occurred as provided in section four thousand one hundred forty of this article.

(e) notwithstanding any contrary provisions of law as may be set forth in this section, commencing on or after the implementation date under section forty-one hundred forty-eight of this title, information and signatures required by this subdivision shall be obtained and made in accordance with section forty-one hundred forty-eight of this title.

§ 4143. Deaths without medical attendance; registration. 1. In case of any death occurring without medical attendance, it shall be the duty of the funeral director, undertaker or any other person to whose knowledge the death may come, to give notice of such death to the coroner of the county, or if there be more than one, to a coroner having jurisdiction, or to the medical examiner.

2. When notified of any death occurring without medical attendance, the coroner or medical examiner shall immediately investigate as provided by law and shall certify as provided in subdivision three. Provided, however, no coroner or medical examiner shall have the authority to investigate a pregnancy loss as provided in section forty-one hundred sixty-one of this article.

3. The coroner or medical examiner whose duty it is to investigate the death and to execute the certificate of death, shall state in such certificate the name of the disease causing death, or if from external causes, the means of death; whether probably accidental, suicidal or homicidal; and shall, in any case, furnish such information as may be required by the commissioner in order to classify the death.

4. In case of any death occurring without medical attendance in the county of Erie, it shall be the duty of the undertaker or other person to whose knowledge the death may come, to notify the medical director of such death, and when so notified the medical director shall immediately investigate and certify as to the cause of death and shall, if such medical director has reason to believe that the death may have been due to an unlawful act or neglect, cause a proper investigation and certification in accordance with the provisions of this section. Provided, however, the medical director shall not have the authority to investigate a pregnancy loss as provided in section forty-one hundred sixty-one of this article.

§ 4144. Deaths; burial and removal permits; transportation of remains.

1. The body of any person whose death occurs in this state, or which shall be found dead herein shall not be interred, deposited in a vault or tomb, cremated or otherwise disposed of, or removed from this state, or be temporarily held pending further disposition more than seventy-two hours after death, unless a permit for burial, removal, or other disposition thereof shall have been properly issued by the registrar of vital statistics of the registration district in which the death occurred or the body was found; provided, however, that a licensed funeral director may apply for and receive such permit on behalf of any person or institution authorized by article forty-two or forty-three of this chapter to receive unclaimed cadavers or anatomical gifts.

2. (a) No burial or removal permit shall be issued by any registrar until, wherever practicable, a complete and satisfactory certificate of death has been filed with him as provided in this article.

(b) The funeral director or undertaker who shall make any removal before a permit is issued by the registrar, shall return the body to the registration district where death occurred, whenever the coroner, medical examiner, or district attorney shall request such return of the body for investigation or post-mortem examination.

(c) Except as specifically provided in this section, the existing general duties of, and remuneration received by, local registrars in accepting and filing certificates of death and issuing burial and removal permits pursuant to any statute or regulation shall be maintained, and not altered or abridged in any way by this section.

3. No registrar of vital statistics shall receive any fee for the issuance of burial or removal permits under this chapter except as referenced by section forty-one hundred forty-eight of this title and other than the compensation provided in this article.

4. When the body of a deceased person is transported from outside of the state into a registration district in this state for burial or other disposition, the transit or removal permit issued in accordance with the law and health regulations of the place where the death occurred shall be given the same force and effect as the burial permit herein provided for.

5. If the interment, or other disposition of the body of a deceased person is to be made within the state, the wording of the burial or removal permit may be limited to a statement by the registrar, and over his signature, that a satisfactory certificate of death, having been filed with him, as required by law, permission is granted to inter, remove or otherwise dispose of the body, stating the name, age, sex, cause of death, and other necessary details in a manner and format as may be required by the commissioner.

6. Notwithstanding any other provision of law, the commissioner shall have power to promulgate rules with reference to the removal of bodies of persons whose deaths occur on trains, boats or other carriers engaged in the transportation of persons within this state, and with reference to the removal of bodies as provided herein.

§ 4145. Deaths; burial and removal permits; disposition of remains.

1. No person in charge of any premises on which interments, cremations, natural organic reductions or other disposition of the body of a deceased person are made shall inter or permit the interment or other disposition of any body unless it is accompanied by a burial, cremation, natural organic reduction or transit permit, as provided in this article.

2. (a) The funeral director or undertaker shall deliver the burial permit to the person in charge of the place of burial or other disposition before interring or otherwise disposing of the body or shall attach the removal or transit permit to the box containing the body, when shipped by any transportation company, which permit shall accompany the remains to its destination, where, if within this state, it shall be delivered to the person in charge of the place of burial or other disposition.

(b) Any person or other entity owning, operating, managing, or designated to receive the body of a deceased person at a place of burial, cremation, natural organic reduction, or other final disposition in this state, who receives the body of a deceased person, shall provide a receipt for the body to the funeral director, undertaker or registered resident who delivered such body. Each receipt shall (i) be endorsed by both such person and the funeral director, undertaker or registered resident, (ii) indicate the date the body was delivered, (iii) include the name of the funeral director, undertaker or registered resident delivering the body and the registration number of such funeral director, undertaker or registered resident, (iv) include the name of the registered funeral firm the funeral director, undertaker or registered resident represents, (v) include the name of the deceased person as it appears on the burial, cremation, natural organic reduction, or transit permit, and (vi) include the name of the owner, operator, manager, or person in charge of the place of burial, cremation, natural organic reduction, or other final disposition who received the body of the deceased person. A copy of such receipt shall be retained by the owner, operator, manager, or person in charge of the

place of burial, cremation, natural organic reduction, or other final disposition for a period of not less than four years, and shall be made available for inspection by the division of cemeteries during normal business hours. The original copy of every such receipt shall be retained by the licensed funeral firm for a period of not less than four years pursuant to the rules and regulations of the department governing the maintenance of records.

3. The person in charge of the place of burial or other disposition shall endorse upon the permit, the date of interment, natural organic reduction, or cremation or other disposition over his signature, and shall return all permits so endorsed to the registrar of his district within seven days after the date of interment, cremation, natural organic reduction, or other disposition.

4. When burying or otherwise disposing of the body of a deceased person in a cemetery or burial place having no person in charge, the funeral director or undertaker shall (a) sign the burial or removal permit, giving the date of burial; (b) write across the face of the permit the words "No person in charge;" and (c) file the burial or removal permit within three days with the registrar of the district in which the cemetery is located.

5. The person in charge of the place of burial, cremation, natural organic reduction, or other disposition shall keep a record of all bodies interred or otherwise disposed of on the premises under his charge, in each case stating the name of each deceased person, place of death, date of burial or disposal, and name and address of the funeral director or undertaker, which record shall at all time be open to official inspection.

6. For the purposes of this section, such documents required to be produced under this section may be signed by written instrument or the use of an electronic signature, as that term is defined in subdivision three of section three hundred two of the state technology law, with the intent to execute the instrument, writing or electronic record.

§ 4146. Deaths; burial permits; interments in certain cemeteries

prohibited. 1. Whenever the legislative authority of any municipality shall deem that further interments in any cemetery in such municipality would be detrimental to the public health, it may by resolution direct its clerk to cause a notice to be served upon the person or corporation owning or controlling such cemetery, and to publish said notice once a week for three successive weeks in two papers published in such city, stating a time and place not less than thirty days after service and first publication of such notice, at which any person interested may show cause to the legislative authority why further interments in such cemetery should not be prohibited.

2. At the time and place specified in such notice the legislative authority of such municipality shall hear all persons desiring to be heard, and if upon such hearing it appears that further interments in such cemetery will be detrimental to public health, it may by resolution prohibit further interments therein.

3. If such resolution is adopted a certified copy thereof shall be filed with the board of health of the municipality in which the cemetery is located, and thereafter permits for interments in such cemetery shall not be issued. The action of the legislative authority in passing such resolution may be reviewed within thirty days thereafter under and pursuant to article seventy-eight of the civil practice act.

4. A burial permit issued by any registrar of vital statistics authorizing burial in such cemetery shall be deemed null and void and of no legal effect after a copy of the resolution has been filed with the board of health of the municipality.

§ 4147. Deaths; confidentiality of records. The death certificate, burial permit or any other record of death or interment, as defined by article forty-one of this chapter, including but not limited to the name, address or telephone number of the decedent, next of kin or surviving relatives of such decedent, shall not be sold or offered for

sale for commercial, promotional or profit-making purposes without the written consent of the next of kin or the legal representative of such decedent or next of kin. The provisions of this section shall not apply to newspapers or newsletters providing general information to the public. A violation of this section shall constitute a violation as defined in the penal law.

§ 4148. Electronic death registration system. 1. The department is hereby authorized and directed to design, implement and maintain an electronic death registration system for collecting, storing, recording, transmitting, amending, correcting and authenticating information, as necessary and appropriate to complete a death registration, and to generate such documents as determined by the department in relation to a death occurring in this state. As part of the design and implementation of the system established by this section, the department shall consult with all persons authorized to use such system to the extent practicable and feasible. Except as specifically provided in this section, the existing general duties of, and remuneration received by, local registrars in accepting and filing certificates of death and issuing burial and removal permits pursuant to any statute or regulation shall be maintained, and not altered or abridged in any way by this section.

2. Commencing on the implementation date, the department shall require that deaths occurring within this state must be registered using the electronic death registration system established in this section. Electronic death registration may be phased in, as determined by the commissioner, for deaths occurring in the state until the electronic death registration system is fully implemented in the state. As used in this section, "implementation date" means the first day in January in the second year after this section becomes a law, or as soon thereafter as the commissioner reasonably determines by regulation is feasible in light of the intent of this section.

3. Commencing on the implementation date, all persons required to register a death or file a certificate of death under this article, and such others as may be authorized by the commissioner, shall have access

to the electronic death registration system for the purpose of entering information required to execute, complete and file a certificate of death or to retrieve such information or generate documentation from the electronic death registration system. The confidentiality provisions in section forty-one hundred forty-seven of this title shall apply to information maintained in this system.

4. Notwithstanding any provision of law to the contrary, commencing on or after January first, two thousand fifteen, or on such date determined by the commissioner pursuant to subdivision two of this section, any requirement of this title for a signature of any person shall be deemed satisfied by the use by such person of digital signature provided such person is authorized in accordance with this section to use the electronic death registration system.

TITLE V

REPORTING OF PREGNANCY LOSS

Section 4160. Pregnancy loss; reporting.

4160-a. Certificate of still birth.

4161. Pregnancy loss certificates; form and content; health care professionals and hospital administrators.

4162. Products of conception; burial and removal; permits.

4163. Penalties.

§ 4160. Pregnancy loss; reporting. 1. Pregnancy loss is defined as the loss of a pregnancy at any gestation, as confirmed by a health care provider licensed pursuant to title eight of the education law and acting within such health care provider's scope of practice, including spontaneous miscarriage, still birth, or any termination of pregnancy which is consistent with the requirements of article twenty-five-A of this chapter.

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

of such loss.

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

* NB Effective until March 30, 2027

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

* NB Effective March 30, 2027

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

§ 4160-a. Certificate of still birth. 1. The department, or in the city of New York, the New York city department of health and mental hygiene, shall establish a certificate of still birth. The department, or in the city of New York, the New York city department of health and mental hygiene, shall issue a certificate of still birth upon the request of such parent or parents who experienced the still birth. If both parents are deceased at the time of the still birth, the department, or in the city of New York, the New York city department of health and mental hygiene shall issue the certificate to, and upon the

request of, the lawful estate representative, the sibling, parent, or parents of the parents.

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

3. The provider attending the still birth or such provider's designee shall inform the parents in writing, of the right to receive a certificate of still birth. Provided, however that if both parents are deceased at the time of such stillbirth, then the person shall so inform the lawful estate representative, sibling, parent or parents of the parent or parents.

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

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

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

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

8. A certificate of still birth may be requested and issued regardless of the date on which the pregnancy loss certificate was issued.

9. The department, or in the city of New York, the New York city department of health and mental hygiene shall not charge any fee for the issuance of a certificate under this section.

10. This section shall apply to the city of New York, notwithstanding section forty-one hundred four of this article.

§ 4161. Pregnancy loss certificates; form and content; health care professionals and hospital administrators. 1. The certificate of pregnancy loss and the report of pregnancy loss shall contain such information and be in such form as the commissioner may prescribe; provided however that commencing on or after the implementation date under section forty-one hundred forty-eight of this article, information and signatures required by this subdivision shall be obtained and made in accordance with section forty-one hundred forty-eight of this article, except that unless requested by the individual who experienced the pregnancy loss neither the certificate nor the report of pregnancy loss shall contain the name of the individual, such individual's social security number or any other information, alone or in combination, which would permit such individual to be identified except as provided in this subdivision. The report shall state that a certificate of pregnancy loss was filed with the commissioner and the date of such filing.

2. In each case where a health care provider licensed pursuant to title eight of the education law and acting within the scope of such health care provider's practice was in attendance at or after a pregnancy loss, it is the duty of such health care provider to certify the pregnancy loss certificate.

3. Where a pregnancy loss occurs without the attendance of a health care provider as provided in subdivision two of this section and the individual experiencing the pregnancy loss seeks disposition of the products of conception in accordance with section forty-one hundred sixty-two of this title, such individual may present themselves to the coroner or medical director of the county, or if there be more than one, to a coroner having jurisdiction, or to the medical examiner to certify the pregnancy loss certificate. Provided, however, nothing in this section shall provide the coroner, medical director, or medical examiner with the authority to investigate an individual who experienced a pregnancy loss.

4. When a pregnancy loss occurs in a hospital, except in those cases where certificates are issued by coroners or medical examiners, the person in charge of such hospital or such person's designated representative shall ensure that the certificate is promptly prepared in accordance with the provisions of this article and regulations as promulgated by the commissioner.

5. A local registrar shall not charge a fee for the issuance of a certificate of pregnancy loss under this article.

§ 4162. Products of conception; burial and removal; permits. 1. Upon request a permit shall be issued for the removal, transportation, burial or other disposition of products of conception.

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

§ 4163. Penalties. Any person who shall release information which might disclose the identity of the pregnant person in connection with a certificate of pregnancy loss or report of pregnancy loss in violation

of the provisions of this title shall be subject to a civil penalty not to exceed five thousand dollars for each such release. Such penalty may be recovered in the same manner as the penalty provided in section twelve of this chapter.

TITLE V-A
INDUCED VIABLE BIRTHS

TITLE VI
REGISTRATION OF PERSONS IN INSTITUTIONS

Section 4165. Persons in institutions; registration.

§ 4165. Persons in institutions; registration. 1. Directors, superintendents, managers or other persons in charge of hospitals, homes for indigents, lying-in or other institutions, public or private, to which persons resort for treatment of diseases or confinement, or to which persons are committed by process of law, shall make, at the time of their admittance, a record of all the personal and statistical particulars relative to the patients and incarcerated individuals in their institutions, which are required in the forms of the certificate provided for by this article as directed by the commissioner.

2. The personal particulars and information required by this section shall be obtained from the patient or incarcerated individual, if it is practicable to do so; and when they cannot be so obtained, they shall be obtained in as complete a manner as possible from relatives, friends, or other persons acquainted with the facts.

3. In the case of persons admitted or committed for treatment of disease, the physician in charge shall specify for entry in the record, the nature of the disease, and where, in his opinion, it was contracted.

4. The records of patients or incarcerated individuals obtained in accordance with this section shall not be sold to any person for

promotional or profit-making purposes without the written consent of such patient or incarcerated individual or the written consent of the legal representative of such patient or incarcerated individual.

TITLE VII

VITAL STATISTICS RECORDS

Section 4170. Records; general duties of registrars.

4171. Records; duties of physicians, nurse practitioners, and others to furnish information.

4172. Records; registrar to transmit through health officers.

4173. Records; transcripts and certifications by registrars; fees.

4174. Records; transcripts and certifications by commissioner; fees.

4175. Records; unrecorded births and deaths.

4176. Records; correction of defective registration.

4177. Vital records; refund of fees.

4179. Vital records; fees; city of New York.

§ 4170. Records; general duties of registrars. Each registrar shall:

(a) supply blank forms of certificates to such persons as require them;

(b) examine each certificate of birth or death when presented for record in order to ascertain whether or not it has been made out in accordance with the provisions of this article and the instructions of the commissioner;

(c) number consecutively the certificates of birth and death, in two separate series, beginning with the number one for the first birth and the first death, in each calendar year, and sign his name as registrar in attest of the date of filing in his office;

(d) make a complete and accurate copy of each birth and death certificate registered by him in such form as approved by the commissioner;

(e) file the permit for each burial, or cremation or other disposition of bodies of deceased persons in his district as the local record, in

such manner as directed by the commissioner and which shall be subject to disposition at such time and in such manner as may be prescribed by rules and regulations promulgated by the commissioner;

(f) at such times as the commissioner shall direct, and as otherwise ordered by the commissioner as provided in section four thousand one hundred seventy-two of this chapter transmit to the commissioner all original certificates, including reports of foundlings, as required by section three hundred ninety-eight of the social services law, and orders relating to parentage registered by him;

(g) maintain a count of reports of fetal death with such reports to be destroyed at the end of each month.

(h) immediately notify the division of criminal justice services in the event that a copy of a birth certificate or information concerning the birth records of any person whose record is flagged pursuant to paragraph (i) of subdivision two of section four thousand one hundred of this article is requested. In the event that a copy of the birth certificate of a person whose record is so flagged is requested in person, the registrar's personnel accepting the request shall immediately notify his or her supervisor who shall notify the local law enforcement agency and department in accordance with regulations promulgated by the department. The person making the request shall complete a form as prescribed by the commissioner, which shall include the name, address, telephone numbers and social security numbers of the person making the request. A motor vehicle operator's license, or if such license is not available, such other identification as the commissioner determines to be satisfactory, shall be presented, photocopied and returned to him or her. When a copy of the birth certificate of a person whose record has been flagged is requested in writing, the registrar shall notify the local law enforcement agency and the department in accordance with regulations promulgated by the department.

§ 4171. Records; duties of physicians, nurse practitioners, and others to furnish information. 1. Physicians, nurse practitioners, nurse-midwives, funeral directors, undertakers and informants, and all other persons having knowledge of the facts, are hereby required to

supply, upon a form provided by the commissioner or upon the original certificate, such information as they may possess regarding any birth or death upon demand of the commissioner, in person, by mail, or through the registrar.

2. No forms shall be used other than those supplied by the commissioner.

3. All certificates, either of birth or death, shall be written legibly, in durable black ink, provided, however, that commencing on or after the implementation date under section forty-one hundred forty-eight of this article, death certificates shall be completed in accordance with section forty-one hundred forty-eight of this article. No certificate, whether filed in paper form or death certificate filed electronically in accordance with section forty-one hundred forty-eight of this article, shall be held to be complete and correct that does not supply all of the items of information called for therein, or satisfactorily account for their omission.

§ 4172. Records; registrar to transmit through health officers. 1. When the commissioner shall have so ordered, each registrar shall transmit, at such times as the commissioner shall direct, to designated local health units or officials copies of original birth and death certificates which have been registered in such primary registration district, and the statistical abstract of fetal death.

2. Each designated local health unit or official receiving copies of original certificates shall retain such copies thereof pursuant to subdivision one of this section as confidential records subject to such further regulation to assure such confidentiality as may be prescribed by the commissioner.

§ 4173. Records; transcripts and certifications by registrars; fees.
1. Upon request, a certification of birth or of death or a certified copy or certified transcript of a birth or death record shall be issued

by the registrar under regulations prescribed by the commissioner.

2. A certified copy or certified transcript of a birth record shall be issued only upon order of a court of competent jurisdiction or upon a specific request therefor by the person, if eighteen years of age or more, or by a parent or other lawful representative of the person to whom the record of birth relates including an authorized representative of the office of children and family services or a local social services district if the person is in the care and custody or custody and guardianship of such entity.

3. (a) Except as otherwise provided in paragraph (b) of this subdivision, the registrar shall be entitled to a fee of ten dollars for each certification of birth or death or for each certified copy or certified transcript of any record of a birth or of a death or for a certification that a search discloses no record of a birth or of a death, furnished by him to an applicant, except that no fee shall be charged for a search, certification of birth or death or certified copy or certified transcript of a birth or a death record to be used for school entrance, employment certificate or for purposes of public relief or government compensation or when required by the veterans administration to be used in determining the eligibility of any person to participate in the benefits made available by the veterans administration, provided, however, that if such registrar is a city clerk, town clerk or village clerk, he shall collect such fees for and on behalf of the city, town or village in which he serves, provided, however, that an amount equivalent to the sum of such fees shall be paid at least monthly by such city, town or village to such city clerk, town clerk or village clerk entitled to receive fees as a registrar of vital statistics.

(b) Notwithstanding paragraph (a) of this subdivision, in the following county jurisdictions the fee shall be set by the county health commissioner: Chemung, Monroe, Onondaga, Tompkins; and in the following local jurisdictions the fee shall be set by the local legislative body: city of Oswego, city of Albany, city of Jamestown. In such jurisdictions, the fee may be set up to the amount charged by the commissioner as prescribed in subdivision two of section forty-one

hundred seventy-four of this title.

4. All fees for searches, certification, certified copies and certified transcripts collected by a registrar of vital statistics in a state hospital, charitable or penal institution shall be transmitted by him to the executive department, having jurisdiction, management and control of such hospital or institution, to be paid into the state treasury as provided by section one hundred twenty-one of the state finance law.

§ 4174. Records; transcripts and certifications by commissioner; fees.

1. The commissioner or any person authorized by him shall:

(a) upon request, issue to any applicant either a certified copy or a certified transcript of the record of any death registered under the provisions of this chapter (1) when a documented medical need has been demonstrated, (2) when a documented need to establish a legal right or claim has been demonstrated, (3) when needed for medical or scientific research approved by the commissioner, (4) when needed for statistical or epidemiological purposes approved by the commissioner, (5) upon specific request by municipal, state or federal agencies for statistical or official purposes, (6) upon specific request of the agent charged with controlling disposition of a decedent's remains, as designated pursuant to subdivision three of section four thousand two hundred one of this chapter, spouse, domestic partners as defined in paragraph (c) of subdivision one of section four thousand two hundred one of this chapter, children, siblings or, parents of the deceased or the lawful representative of such persons, or (7) pursuant to the order of a court of competent jurisdiction on a showing of necessity; except no certified copy or certified transcript of a death record shall be subject to disclosure under article six of the public officers law;

(b) issue certified copies or certified transcripts of birth certificates only (1) upon order of a court of competent jurisdiction, or (2) upon specific request therefor by the person, if eighteen years of age or more, or by a parent or other lawful representative of the person, to whom the record of birth relates including authorized representatives of a local social services district if the person is in

the care and custody or custody and guardianship of such district, or (3) upon specific request therefor by a department of a state or the federal government of the United States;

(c) upon request, issue a wallet-size certification of birth, in a form and bearing a design provided by the commissioner. Each applicant for a wallet-size certification of birth shall remit to the commissioner with such application, a fee determined by the department;

(d) upon request, issue certification of birth or death unless in his judgment it does not appear to be necessary or required for a proper purpose;

(e) furnish non-identifiable statistical information in tabular or machine readable format for research activities if satisfied that the same is required for a proper purpose, and the commissioner is authorized to fix and to require payment of a fee sufficient to compensate the state for the expense of providing the requested information;

(f) be deemed to have complied with the applicable provisions of paragraphs (a) and (b) of this subdivision by the issuance of a certified transcript of the desired certificate or record instead of a certified copy thereof except where the requester shall show, to the satisfaction of the commissioner or his authorized representative, a demonstrated need for such certified copy, or where a court order rendered pursuant to the provisions of paragraph (b) of this subdivision contains an express recital or direction therein that the issuance of a certified transcript of such certificate or record in place of a certified copy thereof shall not be considered to be in compliance therewith;

(g) upon request of a board of elections, issue certification of death.

2. Each applicant for a certification of birth or death, certificate of birth data or for a certified copy or certified transcript of a birth or death certificate or certificate of birth data shall remit to the commissioner with such application a fee of thirty dollars in payment for the search of the files and records and the furnishing of a certification, certified copy or certified transcript if such record is found or for a certification that a search discloses no record of a

birth or of a death.

3. For any search of the files and records conducted for authorized genealogical or research purposes, the commissioner or any person authorized by him shall be entitled to, and the applicant shall pay, a fee of twenty dollars for each hour or fractional part of an hour of time of search, together with a fee of two dollars for each uncertified copy or abstract of such record requested by the applicant or for a certification that a search discloses no record.

4. No fee shall be charged for a search, certification, certificate, certified copy or certified transcript of a record to be used for school entrance, employment certificate or for purposes of public relief or when required by the veterans administration to be used in determining the eligibility of any person to participate in the benefits made available by the veterans administration or when required by a board of elections for the purposes of determining voter eligibility or when requested by the department of corrections and community supervision or a local correctional facility as defined in subdivision sixteen of section two of the correction law for the purpose of providing a certified copy or certified transcript of birth to an incarcerated individual in anticipation of such incarcerated individual's release from custody or to obtain a death certificate to be used for administrative purposes for an incarcerated individual who has died under custody or when requested by the office of children and family services or an authorized agency for the purpose of providing a certified copy or certified transcript of birth to a youth placed in the care and custody or custody and guardianship of the local commissioner of social services or the care and custody or custody and guardianship of the office of children and family services in anticipation of such youth's discharge from placement or foster care. Whenever a request is made by the department of corrections and community supervision for a certified copy or certified transcript of birth on behalf of an incarcerated individual pursuant to this section, a certified copy of the sentence and commitment or certificate of conviction shall be deemed to grant authorization by the incarcerated individual to the department to submit such request on their behalf, and no other authorization shall

be required.

5. (a) The United States social security administration may obtain information from death certificates needed in the administration of old-age and survivors insurance benefits laws, subject to the provisions of any contract entered into pursuant to paragraph (b) of this subdivision.

(b) In addition, the commissioner or any person authorized by the commissioner is authorized and directed to enter into a contract to furnish the federal secretary of health and human services information concerning individuals with respect to whom death certificates have been officially filed with the commissioner. Such contract shall not include any restriction on the use of information obtained by such secretary pursuant to such contract, except that such contract may provide that such information is only to be used by the secretary (or any other federal agency) for purposes of ensuring that federal benefits or other payments are not erroneously paid to deceased individuals.

6. The federal agency in charge of vital statistics may obtain, at a fee acceptable to the commissioner, information from birth and death certificates for use solely as statistical data.

7. Except as herein otherwise provided, the commissioner is authorized to establish rules and regulations whereby searches may be made and certifications, certified copies and certified transcripts of birth and death certificates furnished without fees to federal, state and municipal departments for official purposes.

8. The commissioner, the commissioner of health of the city of New York, or any person authorized by the commissioner having jurisdiction shall immediately notify the division of criminal justice services in the event that a copy of a birth certificate or information concerning the birth records of any person whose record is flagged pursuant to paragraph (i) of subdivision two of section four thousand one hundred of this article is requested. In the event that a copy of the birth certificate of a person whose record is so flagged is requested in person, the personnel accepting the request shall immediately notify his

or her supervisor. The person making the request shall complete a form as prescribed by the commissioner or, in the city of New York, the commissioner of health of the city of New York, which shall include the name, address and telephone numbers and social security number of the person making the request. A motor vehicle operator's license, or if such license is not available, such other identification as the commissioner, or in the city of New York, the commissioner of the New York city department of health, determines to be satisfactory, of the person making the request shall be presented, shall be photocopied and returned to him or her. The person receiving the request shall note the physical description of the person making the request and his or her supervisor shall immediately notify the local law enforcement authority as to the request and the information obtained pursuant to this subsection. When a copy of the birth certificate of a person whose record has been flagged is requested in writing, the law enforcement authority having jurisdiction shall be notified as to the request and shall be provided with a copy of the written request. The registrar shall retain the original written response.

9. The commissioner may institute an additional fee of fifteen dollars for priority handling for each certification, certified copy or certified transcript of certificates of birth, death, or dissolution of marriage; or fifteen dollars for priority handling for each certification, certified copy or certified transcript of certificate of marriage.

§ 4175. Records; unrecorded births and deaths. 1. If, at any time after the birth, or within one year of the death, of any person within the state, a certified copy of the official record of said birth or death, with the information required to be registered by this article, is necessary for legal, judicial, or other proper purposes, and, after search by the commissioner or his or her representatives, it appears that no such certificate of birth or death was made and filed as provided by this article, then the commissioner shall immediately require the physician, nurse practitioner, or nurse-midwife who, being in attendance upon a birth, failed or neglected to file a certificate

thereof, or the funeral director, undertaker, or other person who, having charge of the interment or removal of the body of a deceased person, failed or neglected to file the certificate of death, if he or she is living, to obtain and file at once with the local registrar such certificate in as complete form as the lapse of time will permit.

2. With said delayed certificate shall be filed such statements subscribed and affirmed by the persons making them as true under the penalties of perjury and other evidence as may be required by the commissioner.

3. If the physician, nurse practitioner, nurse-midwife, funeral director, or undertaker responsible for the report is deceased or cannot be located, then the person making application for the certified copy of the record may file such certificate of birth or death together with such statements subscribed and affirmed by the persons making them as true under the penalties of perjury and other evidence as the commissioner may require.

4. The commissioner shall file such certificate and issue a certified copy thereof to said applicant without fee.

5. The delinquent physician, nurse practitioner, nurse-midwife, funeral director, undertaker, or other person may, in the discretion of the commissioner, be prosecuted as required by this article, without bar from the statute of limitations, if he or she neglects or fails to file promptly the certificate required by this section.

§ 4176. Records; correction of defective registration. 1. If defects be found in the registration under the supervision of a registrar of vital statistics, the commissioner shall notify such registrar that such defects must be corrected within ten days of the date of the notice.

2. If such defects are not so corrected the commissioner shall take control of such registration and of the records thereof, and enforce the rules and regulations in regard thereto and secure a complete

registration in such district, and such control shall continue until the registrar of vital statistics shall satisfy the commissioner that he will make such record and registry complete as required by law and in the sanitary code.

3. The expenses incurred by the commissioner or his authorized representative while in control of such registration shall be a charge upon the city, town or village comprising the registration district.

4. No certificate of birth or death, after its acceptance for registration by the registrar, and no new certificate or other record made in pursuance of this article, shall be altered or changed in any respect except to correct errors made in completing the certificate by the person responsible for preparing the certificate or as otherwise provided in this article. The commissioner shall provide the application form for a correction of a record which must be properly dated, signed and witnessed, or subscribed and affirmed by the persons making them as true under the penalties of perjury, together with such supporting proofs as may be prescribed by the commissioner.

§ 4177. Vital records; refund of fees. Moneys received pursuant to this article may within one year from the receipt thereof be refunded on proof satisfactory to the commissioner that such moneys were in excess of amounts required by law. Such refund shall after audit by the comptroller be paid by the commissioner from any moneys in the custody of the commissioner received pursuant to this article.

§ 4179. Vital records; fees; city of New York. Notwithstanding the provisions of paragraph one of subdivision a of section 207.13 of the health code of the city of New York, the department of health shall charge, and the applicant shall pay, for a search of two consecutive calendar years under one name and the issuance of a certificate of birth, death or termination of pregnancy, or a certification of birth or death, or a certification that the record cannot be found, a fee of fifteen dollars for each copy. Provided, however, that no such fee shall

be charged when the department of corrections and community supervision or a local correctional facility as defined in subdivision sixteen of section two of the correction law requests a certificate of birth or certification of birth for the purpose of providing such certificate of birth or certification of birth to an incarcerated individual in anticipation of such incarcerated individual's release from custody or to obtain a death certificate to be used for administrative purposes for an incarcerated individual who has died under custody or when the office of children and family services or an authorized agency requests a certified copy or certified transcript of birth for a youth placed in the custody of the local commissioner of social services or the custody of the office of children and family services pursuant to article three of the family court act for the purpose of providing such certified copy or certified transcript of birth to such youth in anticipation of discharge from placement. Whenever a request is made by the department of corrections and community supervision for a certified copy or certified transcript of birth on behalf of an incarcerated individual pursuant to this section, a certified copy of the sentence and commitment or certificate of conviction shall be deemed to grant authorization by the incarcerated individual to the department to submit such request on their behalf, and no other authorization shall be required.

ARTICLE 42

CADAVERS

Title I. Disposition (Secs. 4200-4203).

II. Autopsy and dissection (Secs. 4209-4222).

TITLE I

DISPOSITION

Section 4200. Cadavers; duty of burial.

4201. Disposition of remains; responsibility therefor.

4202. Cremated remains; disposition.

4203. Cremated or naturally organically reduced remains of a veteran; disposition.

§ 4200. Cadavers; duty of burial. 1. Except in the cases in which a right to dissect it is expressly conferred by law, every body of a deceased person, within this state, shall be decently buried, naturally organically reduced, or incinerated within a reasonable time after death.

2. The provisions of this section shall not impair the right to carry the body of a deceased person through this state, or to remove from this state the body of a person who has died within it, for the purpose of burying the same elsewhere.

§ 4201. Disposition of remains; responsibility therefor. 1. As used in this section, the following terms shall have the following meanings, unless the context otherwise requires:

(a) "Cremation" means the incineration of human remains.

(b) "Disposition" means the care, disposal, transportation, burial, cremation, natural organic reduction or embalming of the body of a deceased person, and associated measures.

(c) "Domestic partner" means a person who, with respect to another person:

(i) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or any state, local or foreign jurisdiction, or registered as the domestic partner of the person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(ii) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(iii) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under subparagraph

(i) or (ii) of this paragraph; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" shall also not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

(c-1) "Natural organic reduction" means the contained, accelerated conversion of human remains to soil.

(d) "Person" means a natural person eighteen years of age or older.

2. (a) The following persons in descending priority shall have the right to control the disposition of the remains of such decedent; provided that if there are more than two members of a class listed in subparagraph (iii), (v), or (vii) of this paragraph entitled to control the disposition of remains of a decedent, the disposition shall be determined by a majority of the members of the class who are reasonably available:

(i) the person designated in a written instrument executed pursuant to the provisions of this section;

(ii) the decedent's surviving spouse;

(ii-a) the decedent's surviving domestic partner;

(iii) any of the decedent's surviving children eighteen years of age or older;

(iv) either of the decedent's surviving parents;

(v) any of the decedent's surviving siblings eighteen years of age or older;

(vi) a guardian appointed pursuant to article seventeen or seventeen-A of the surrogate's court procedure act or article eighty-one of the mental hygiene law;

(vii) any person eighteen years of age or older who would be entitled to share in the estate of the decedent as specified in section 4-1.1 of the estates, powers and trusts law, with the person closest in

relationship having the highest priority;

(viii) a duly appointed fiduciary of the estate of the decedent;

(ix) a close friend or relative who is reasonably familiar with the decedent's wishes, including the decedent's religious or moral beliefs, when no one higher on this list is reasonably available, willing, or competent to act, provided that such person has executed a written statement pursuant to subdivision seven of this section; or

(x) a chief fiscal officer of a county or a public administrator appointed pursuant to article twelve or thirteen of the surrogate's court procedure act, or any other person acting on behalf of the decedent, provided that such person has executed a written statement pursuant to subdivision seven of this section.

(b) If a person designated to control the disposition of a decedent's remains, pursuant to this subdivision, is not reasonably available, unwilling or not competent to serve, and such person is not expected to become reasonably available, willing or competent, then those persons of equal priority and, if there be none, those persons of the next succeeding priority shall have the right to control the disposition of the decedent's remains.

(c) The person in control of disposition, pursuant to this section, shall faithfully carry out the directions of the decedent to the extent lawful and practicable, including consideration of the financial capacity of the decedent's estate and other resources made available for disposition of the remains. The person in control of disposition shall also dispose of the decedent in a manner appropriate to the moral and individual beliefs and wishes of the decedent provided that such beliefs and wishes do not conflict with the directions of the decedent. The person in control of disposition may seek to recover any costs related to the disposition from the fiduciary of the decedent's estate in accordance with section eighteen hundred eleven of the surrogate's court procedure act.

(d) No funeral director, undertaker, embalmer or no person with an interest in, or who is an employee of any funeral firm, cemetery organization or business operating a crematory, natural organic reduction facility, columbarium or any other business, who also controls the disposition of remains in accordance with this section, shall receive compensation or otherwise receive financial benefit for

disposing of the remains of a decedent.

(e) No person who: (1) at the time of the decedent's death, was the subject of an order of protection protecting the decedent; or (2) has been arrested or charged with any crime set forth in article one hundred twenty-five of the penal law as a result of any action allegedly causally related to the death of the decedent shall have the right to control the disposition of the remains of the decedent. However, the application of this paragraph in a particular case may be waived or modified in the interest of justice by order of (i) the court that issued the order of protection or in which the criminal action against the person is pending, or a superior court in which an action or proceeding under the domestic relations law or the family court act between the person and the decedent was pending at the time of the decedent's death, or (ii) if proceeding in that court would cause inappropriate delay, a court in a special proceeding.

3. The written instrument referred to in paragraph (a) of subdivision two of this section may be in substantially the following form, and must be signed and dated by the decedent and the agent and properly witnessed:

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

I, _____

(Your name and address)

being of sound mind, willfully and voluntarily make known my desire that, upon my death, the disposition of my remains shall be controlled by _____ .

(name of agent)

With respect to that subject only, I hereby appoint such person as my agent with respect to the disposition of my remains.

SPECIAL DIRECTIONS:

Set forth below are any special directions limiting the power granted to my agent as well as any instructions or wishes desired to be followed in the disposition of my remains:

Indicate below if you have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law for funeral merchandise or service in advance of need:

☐ No, I have not entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

☐ Yes, I have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

(Name of funeral firm with which you entered into a pre-funded pre-need funeral agreement to provide merchandise and/or services)

AGENT:

Name: _____

Address: _____

Telephone Number: _____

SUCCESSORS:

If my agent dies, resigns, or is unable to act, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent to control the disposition of my remains as authorized by this document:

1. First Successor

Name: _____

Address: _____

Telephone Number: _____

2. Second Successor

Name: _____

Address: _____

Telephone Number: _____

DURATION:

This appointment becomes effective upon my death.

PRIOR APPOINTMENT REVOKED:

I hereby revoke any prior appointment of any person to control the

disposition of my remains.

Signed this _____ day of _____, _____.

(Signature of person making the appointment)

Statement by witness (must be 18 or older)

I declare that the person who executed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____

(signature)

Address: _____

Witness 2: _____

(signature)

Address: _____

ACCEPTANCE AND ASSUMPTION BY AGENT:

1. I have no reason to believe there has been a revocation of this appointment to control disposition of remains.

2. I hereby accept this appointment.

Signed this _____ day of _____, _____.

(Signature of agent)

4. (a) In the absence of a written instrument made pursuant to subdivision three of this section, the designation of a person for the disposition of one's remains or directions for the disposition of one's remains in a will executed pursuant to the laws of the state of New York prior to the effective date of this section, or otherwise executed pursuant to the laws of a jurisdiction outside the state of New York, shall be: (i) considered reflective of the intent of the decedent with respect to the disposition of the decedent's remains; and (ii) superseded by a written instrument subsequently executed pursuant to

subdivision three of this section, or by any other subsequent act by the decedent evidencing a specific intent to supersede the designation or direction in such a will with respect to the disposition of the decedent's remains. All actions taken reasonably and in good faith based upon such authorizations and directions regarding the disposition of one's remains in such a will shall be deemed valid regardless of whether such a will is later probated or subsequently declared invalid.

(b) In the absence of a written instrument made pursuant to subdivision three of this section, the designation of a person for the disposition of one's remains or directions for the disposition of one's remains in a will executed pursuant to the laws of the state of New York on or after the effective date of this section, shall be considered a reflection of the intent of the decedent with respect to the disposition of the decedent's remains, provided that the person who represents that he or she is entitled to control the disposition of remains of the decedent has complied with subdivision five and paragraph (a) of subdivision seven of this section and signed a written statement in accordance with paragraph (b) of subdivision seven of this section.

4-a. A written instrument under this section may limit the disposition of remains agent's authority to consent to organ or tissue donation or designate another person to do so, under article forty-three of this chapter. Failure to state wishes or instructions shall not be construed to imply a wish not to donate.

5. A written instrument executed under this section shall be revoked upon the execution by the decedent of a subsequent written instrument, or by any other subsequent act by the decedent evidencing a specific intent to revoke the prior written instrument and directions on disposition and agent designations in a will made pursuant to subdivision three of this section shall be superseded by a subsequently executed will or written instrument made pursuant to this section, or by any other subsequent act of the decedent evidencing a specific intent to supersede the direction or designation. The designation of the decedent's spouse or domestic partner as an agent in control of disposition of remains shall be revoked upon the divorce or legal separation of the decedent and spouse, or termination of the domestic

partnership, unless the decedent specified in writing otherwise.

6. A person acting reasonably and in good faith, shall not be subject to any civil liability for:

(a) representing himself or herself to be the person in control of a decedent's disposition;

(b) disposing of a decedent's remains if done with the reasonable belief that such disposal is consistent with this section; or

(c) identifying a decedent.

7. No cemetery organization, business operating a crematory, natural organic reduction facility, or columbarium, funeral director, undertaker, embalmer, or funeral firm shall be held liable for actions taken reasonably and in good faith to carry out the written directions of a decedent as stated in a will or in a written instrument executed pursuant to this section. No cemetery organization, business operating a crematory, natural organic reduction facility, or columbarium, funeral director, undertaker, embalmer or funeral firm shall be held liable for actions taken reasonably and in good faith to carry out the directions of a person who represents that he or she is entitled to control of the disposition of remains, provided that such action is taken only after requesting and receiving written statement that such person:

(a) is the designated agent of the decedent designated in a will or written instrument executed pursuant to this section; or

(b) that he or she has no knowledge that the decedent executed a written instrument pursuant to this section or a will containing directions for the disposition of his or her remains and that such person is the person having priority under subdivision two of this section.

8. Every dispute relating to the disposition of the remains of a decedent shall be resolved by a court of competent jurisdiction pursuant to a special proceeding under article four of the civil practice law and rules. No person providing services relating to the disposition of the remains of a decedent shall be held liable for refusal to provide such services, when control of the disposition of such remains is contested, until such person receives a court order or other form of notification

signed by all parties or their legal representatives to the dispute establishing such control.

9. This section does not supersede, alter or abridge any provision of section four hundred fifty-three of the general business law. In the event of a conflict or ambiguity, the provisions of section four hundred fifty-three of the general business law shall govern.

10. This section does not supersede, alter or abridge any provision of article forty-three of this chapter including, but not limited to, the persons authorized to execute an anatomical gift pursuant to section forty-three hundred one of this chapter.

11. This section does not diminish the enforceability of a contract or agreement in which a person controlling the disposition of the remains of a decedent agrees to pay for goods or services in connection with the disposition of such remains.

§ 4202. Cremated remains; disposition. 1. Every body delivered to a cemetery for cremation, or natural organic reduction, shall be accompanied by a statement from a physician, coroner, or medical examiner certifying that such body does not contain a battery or power cell. The person in charge of a cemetery may refuse to cremate or naturally organically reduce a body unless accompanied by such statement.

2. Cremated remains means human remains after incineration in a crematory. Naturally organically reduced remains means human remains that have been naturally organically reduced to soil.

3. An institution authorized by article forty-two or forty-three of this chapter to receive unclaimed cadavers or anatomical gifts, notwithstanding any other provision of law, may prepare or preserve cadavers in its lawful possession for purposes of research, study or anatomical instruction and may cremate the cadavers or dissected remains of such cadavers after the completion of such research, study or

anatomical instruction thereon; provided, however, that cremation shall be performed only in a retort used exclusively for such purpose. For the purposes of the provisions of this subdivision, such institution shall not be subject to article fifteen of the not-for-profit corporation law.

4. At the time of the arrangement for a funeral performed by any undertaker or funeral director, the person contracting for funeral services shall designate his intentions with respect to the disposition of the remains of the deceased in a signed declaration of intent on a form as designated by the department which shall be provided by and retained by the undertaker. Every undertaker, administrator, executor, authorized representative of a deceased person, corporation, company or association, or other person having in his or its lawful possession cremated or naturally organically reduced remains, except such remains committed to his or its care for permanent interment, which remains shall not have been claimed by a relative or friend of the deceased person within one hundred twenty days from the date of cremation or natural organic reduction, may dispose of such remains by placement in a tomb, mausoleum, crypt, niche in a columbarium, burial in a cemetery, or scattering of the remains at sea or by otherwise disposing of such remains as provided by rule of the department. A record of such disposition shall be made and kept by the person making such disposition. Upon disposing of such remains in the manner prescribed above, such person shall be discharged from any legal obligation or liability to the authorizing agent or any other person enumerated under paragraph (a) of subdivision two of section forty-two hundred one of this title in relation to such remains.

§ 4203. Cremated or naturally organically reduced remains of a veteran; disposition. 1. As used in this section, the following terms shall have the following meanings:

(a) "veteran" means a deceased person who:

(i) served in the active military or naval service of the United States; or

(ii) served in active duty in a force of any organized state militia in a full-time status; or

(iii) served in the reserve armed forces of the United States in active duty; or

(iv) was a recipient of the armed forces expeditionary medal, navy expeditionary medal, marine corps expeditionary medal or global war on terrorism expeditionary medal; and

(v) was released from such service otherwise than by dishonorable discharge.

(b) "veterans' service organization" means an association, corporation or other entity that qualifies under section 501(c)(3) or section 501(c)(19) of the Internal Revenue Code as a tax-exempt organization that has been organized for the benefit of veterans and recognized or chartered by the United States Congress, including, but not limited to the Disabled American Veterans, the Veterans of Foreign Wars, the American Legion and the Vietnam Veterans of America. The term also includes a member or employee of an eligible non-profit veterans' corporation, association or entity, such as the Missing In America Veteran Recovery Program, that specifically assists in facilitating the identification and internment of unclaimed remains of American veterans.

(c) "national cemetery" means any cemetery under the control of the United States department of veterans' affairs national cemetery administration.

(d) "interment" shall have the meaning set forth in paragraph (g) of section fifteen hundred two of the not-for-profit corporation law.

(e) "disposition" means disposal of cremated or naturally organically reduced remains by placement in a tomb, mausoleum, crypt, niche in a columbarium or burial in a cemetery. Provided, however, for the purpose of this section the term "disposition" shall not include the scattering of cremated or naturally organically reduced remains.

(f) "local veterans' service agencies" shall have the meaning set forth in section three hundred fifty-seven of the executive law.

2. A funeral director, undertaker or funeral firm which has held in its possession cremated or naturally organically reduced remains for more than one hundred twenty days from the date of cremation or natural organic reduction may, in accordance with the provisions of this section, determine if such cremated or naturally organically reduced remains are those of a veteran, and if so, may dispose of such remains

as provided in this section.

3. (a) Notwithstanding any law or regulation to the contrary, nothing in this section shall prevent a funeral director, undertaker or funeral firm from sharing information with the United States department of veterans affairs (VA), a local veterans' service agency, a veterans' service organization, a national cemetery, or county veterans cemetery for the purpose of determining whether the cremated or naturally organically reduced remains are those of a veteran.

(b) A funeral director, undertaker, or funeral firm shall be discharged from any legal obligations or liability with regard to releasing or sharing information to the United States department of veterans affairs, the local veterans' service agencies, veterans' service organizations, a national cemetery, or county veterans cemetery pursuant to this section.

4. (a) Should a funeral director, undertaker or funeral firm ascertain the cremated or naturally organically reduced remains in its possession are those of a veteran, and they have not been instructed by the person in control of the disposition of the decedent to arrange for the final disposal or delivery of the cremated or naturally organically reduced remains, the funeral director, undertaker or funeral firm may dispose of the cremated or naturally organically reduced remains or relinquish possession of the cremated or naturally organically reduced remains to a veterans' service organization.

(b) The method of disposition shall be made pursuant to section forty-two hundred two of this title in a national cemetery, a county veterans cemetery, a section of a cemetery corporation where veterans are memorialized by a veteran's marker if eligible, a veterans' section of a cemetery corporation or a veterans' cemetery if the deceased veteran is eligible for interment in such a manner.

5. The funeral director, undertaker, funeral firm or veterans' service organization notwithstanding any law to the contrary, upon:

(a) disposing of cremated or naturally organically reduced remains in accordance with the provisions of this section, shall be held harmless for any costs or damages, except if there is gross negligence or willful

misconduct; and

(b) shall be discharged from any legal obligation or liability concerning the cremated or naturally organically reduced remains.

6. The estate of the decedent shall be responsible for reimbursing a funeral director, undertaker, funeral firm or veterans' service organization for all reasonable expenses incurred in relation to the disposition of such cremated or naturally organically reduced remains.

7. A funeral director, undertaker or funeral firm shall establish and maintain a record identifying the veterans' service organization receiving the cremated or naturally organically reduced remains and the site designated for final disposition of the cremated or naturally organically reduced remains.

8. Nothing in this section shall require a funeral director, undertaker or funeral firm to determine or seek others to determine that an individual's cremated or naturally organically reduced remains are those of a veteran if the funeral director, undertaker or funeral firm was informed by the person in control of disposition that such individual was not a veteran, or to relinquish possession of such cremated or naturally organically reduced remains to a veterans' service organization if the funeral director, undertaker or funeral firm was instructed by such person in control, or had a reasonable belief, that the decedent did not desire any funeral or burial-related services or ceremonies recognizing such decedent's service as a veteran.

TITLE II

AUTOPSY AND DISSECTION

Section 4209. Autopsies; right to perform.

4209-a. Procedure for obtaining identification by persons opposed to the dissection or autopsy of their bodies upon their death.

4210. Deceased persons; right to dissect.

4210-a. Unlawful dissection of the body of a human being.

4210-b. Certain unauthorized autopsies.

- 4210-c. Limitations to dissection or autopsy.
- 4211. Cadavers; unclaimed; delivery to schools for study.
- 4212. Cadavers; unclaimed; delivery to schools; procedure.
- 4213. Cadavers; delivery to relatives or friends.
- 4214. Cadavers; autopsy by order of hospital authorities.
- 4215. Cadavers; burial after autopsy and dissection.
- 4216. Body stealing.
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- 4220. Disturbing funerals.
- 4221. Removal of eyes and/or parts thereof after death.
- 4222. Removal of corneal tissue for transplant and pituitary gland tissue for the extraction of growth hormone.

§ 4209. Autopsies; right to perform. No person shall make any incision preparatory to or during an autopsy except (a) a duly licensed medical physician or osteopathic physician, (b) a resident physician, (c) a medical intern, (d) a student in a registered medical school, dental school or chiropractic college while under the supervision of the professor or teacher, (e) an instructor of anatomy, (f) a dental resident or licensed dentist while under the supervision of a physician.

A physician performing an autopsy may be assisted by a trained mortuary attendant (diener).

§ 4209-a. Procedure for obtaining identification by persons opposed to the dissection or autopsy of their bodies upon their death. Except as required by law, no dissection or autopsy shall be performed on the body of any person who is carrying an identification card upon his person indicating his opposition to such dissection or autopsy. To be valid, this card must be signed and dated by the person opposed to the dissection or autopsy and must be notarized.

The card shall measure at least two inches by three inches and shall

be made of a cardboard based material. The card shall state:

"I,,
(insert the name of the person opposed to dissection or autopsy)
do not consent to the dissection or autopsy of my body except as is
required by law."

§ 4210. Deceased persons; right to dissect. The right to dissect the body of a deceased person exists in the following cases:

1. In the cases prescribed by special statutes; or,
2. When the dissection is performed by or at the direction of (a) a coroner who is a physician licensed to practice medicine in this state, or (b) a coroner's physician, or (c) a medical examiner of a county, or is performed at the direction jointly of a coroner and coroner's physician, and is performed in the course of an investigation within the jurisdiction of the officer performing or directing the dissection, or is performed upon the written request of a district attorney, or sheriff, or the chief of a police department of a city or county, or the superintendent of state police.

The commissioner shall adopt regulations to establish standard autopsy protocols for any person under the age of one year who dies under circumstances in which death is not anticipated by medical history or the cause is unknown. Such regulations and autopsy protocols shall include but not be limited to (i) requirements for the performance of such autopsies, subject to the limitations provided for in section forty-two hundred ten-c of this title, and (ii) delineation of specific, standardized methods for such autopsies. In developing and implementing such regulations and protocols, the commissioner shall consult with health professionals, families and other persons participating in the implementation of the sudden infant death syndrome program authorized pursuant to section twenty-five hundred-b of this chapter and at a minimum shall consult with an epidemiologist, a forensic pathologist, a pediatric pathologist, a medical examiner, a county coroner and a pediatrician with expertise in sudden infant death syndrome; or,

2-a. Where a person dies while under care or treatment at a general hospital (as defined by subdivision ten of section twenty-eight hundred one of this chapter) or while recovering from such care or treatment, any autopsy report for such person shall be made available, by the coroner or medical examiner under whose jurisdiction the autopsy was performed, in a timely manner, to the hospital, for the purpose of ongoing performance improvement of such hospital, including for the purposes of sections twenty-eight hundred five-j and twenty-eight hundred five-k of this chapter. All such reports in the possession of a hospital shall be subject to the provisions of section twenty-eight hundred five-m of this chapter.

3. Whenever and so far as the husband, wife or next of kin of the deceased, being charged by law with the duty of burial, (a) may authorize dissection for the sole purpose of ascertaining the cause of death, or (b) may authorize dissection for any other purpose by written instrument which shall specify the purpose and extent of the dissection so authorized, and when a dissection is so authorized pursuant to this subdivision the person authorizing the dissection also may designate a physician licensed in any state or country to observe such dissection. If the deceased has upon his person an identification card indicating his opposition to the dissection or autopsy of his body no such dissection or autopsy shall be performed except as required by law; or,

4. Whenever any district attorney in this state, in the discharge of his official duties, shall deem it necessary, he may exhume, take possession of, and remove the body of a deceased person, or any portion thereof, and submit the same to a proper physical or chemical examination, or analysis, to ascertain the cause of death, and the same shall be made on the order of any justice of the supreme court of this state, or the county judge of the county in which such dead body shall be, which order shall be made on the application of the district attorney with or without notice to the relatives of the deceased person or to any person or corporation having the legal charge of such body, as the court may direct. Said district attorney shall have power to direct any police officer or peace officer, acting pursuant to his special

duties, of this state, or to employ such person, or persons as he may deem necessary to assist him in exhuming, removing, obtaining possession of and examining physically or chemically such dead body or any portion thereof. The expense therefor shall be a county charge, to be paid by the county treasurer on the certificate of the district attorney.

5. When an autopsy of the body is conducted of a deceased human who has epilepsy or a history of seizures it shall include an investigation and determinations as to whether the deceased suffered a sudden unexpected death in epilepsy. In the event the deceased did suffer a sudden, unexpected death in epilepsy, such information shall be noted on the death certificate and be reported to the North American SUDEP Registry.

§ 4210-a. Unlawful dissection of the body of a human being. A person who makes, or causes or procures to be made, any dissection of the body of a human being, except by authority of law, or in pursuance of a permission given by the deceased, is guilty of a class E felony.

§ 4210-b. Certain unauthorized autopsies. A person authorized by law to perform a dissection or autopsy who acts in good faith in accordance with the terms of this article but is unaware of the existence of an identification card indicating the decedent's opposition to the dissection or autopsy of his body after a routine examination of the decedent and his effects has been conducted shall not be subjected to prosecution in any criminal proceeding nor held liable for damages in any civil action for his involvement in such an unauthorized autopsy.

§ 4210-c. Limitations to dissection or autopsy. 1. Notwithstanding any other provision of law, in the absence of a compelling public necessity, no dissection or autopsy shall be performed over the objection of a surviving relative or friend of the deceased that such procedure is contrary to the religious belief of the decedent, or, if there is otherwise reason to believe that a dissection or autopsy is contrary to

the decedent's religious beliefs.

2. For the purposes of this section: (a) "compelling public necessity" shall mean:

(i) that the dissection or autopsy is essential to the conduct of a criminal investigation of a homicide, as defined in section 125.00 of the penal law, of which the decedent is the victim, or

(ii) that discovery of the cause of death is necessary to meet an immediate and substantial threat to the public health and that a dissection or autopsy is essential to ascertain the cause of death, or

(iii) that the need for a dissection or autopsy is established in accordance with subdivision five of this section.

(b) "relative" shall mean the person most closely related to the decedent by consanguinity or affinity. In the event such person is unavailable, the objection may be raised on his behalf by the next most closely related person. The official who has authority to order a dissection or autopsy of the decedent's body may require a relative to present an affidavit stating his relationship to the decedent, the religious affiliation of the decedent, if any, that the decedent had religious objections to an autopsy, the basis for such belief, and that he will assume responsibility for the lawful disposition of the body of the deceased.

(c) "friend" shall mean any person who, prior to the decedent's death, maintained such regular contact with the decedent as to be familiar with his activities, health and religious beliefs and who presents an affidavit stating the facts and circumstances upon which the claim that he is such friend is based, the religious affiliation of the decedent, if any, that the decedent had religious objections to an autopsy, the basis for such belief, and that he will assume responsibility for the lawful disposition of the body of the deceased.

3. All dissections or autopsies performed pursuant to this section shall be the least intrusive procedure consistent with the compelling state interest as defined herein.

4. Except as provided in subdivision three of section forty-two hundred ten of this article, no dissection or autopsy shall be performed

over the objection of a surviving relative or friend that such autopsy is contrary to the religious beliefs of the deceased, or where there is otherwise reason to believe that a dissection or autopsy is contrary to the decedent's religious beliefs, until notice thereof is given to the next of kin or friend as defined herein, or until forty-eight hours have elapsed, whichever is greater, to permit an objecting party to institute legal proceedings to determine the propriety of such dissection or autopsy; provided, however, that a court upon ex parte motion may dispense with the waiting period if it determines that such delay may prejudice the accuracy of the autopsy or dissection or if the objecting party is a suspect in the homicide.

5. Whenever any coroner or medical examiner shall deem it necessary to perform an autopsy over the objection of a surviving relative or friend that such autopsy is contrary to the religious beliefs of the deceased, or where there is otherwise reason to believe that a dissection or autopsy is contrary to the decedent's religious beliefs, in circumstances not provided for in subparagraphs (i) and (ii) of paragraph (a) of subdivision two of this section, he may institute a special proceeding, without fee, in the supreme court or county court for an order authorizing such autopsy. Such proceeding shall be instituted as soon as practicable, brought on by an order to show cause on notice to the next of kin or friend, or if none is known to the petitioner, then to such party as the court may direct, returnable at the earliest possible time. The proceeding shall have preference over all other cases in the court and shall be determined summarily upon the petition and such oral or written proof as may be offered by the parties. The court shall grant the relief sought in the petition if it finds that the petitioner had established a demonstrable need for such autopsy or dissection under all circumstances of the case. If the petition is denied, and no stay is granted by the court or the appellate division, the body shall immediately be released for burial to the surviving relative or friend.

§ 4211. Cadavers; unclaimed; delivery to schools for study. 1. Except as hereinafter provided, and subject to the conditions specified in this

article, the director or person in charge of any hospital, institution, morgue or other place for bodies of deceased persons not interred or otherwise finally disposed of, and every funeral director, undertaker or other person having in his or her lawful possession, any body of a deceased person for keeping or burial, shall deliver every body of a deceased person in his or her possession, charge, custody or control not placed therein by any person, agency or organization for keeping, burial or other lawful disposition to:

(a) any medical college, school or institute including chiropractic colleges registered by the regents of the university of the state of New York as maintaining a proper standard;

(b) any university within the state authorized by law to confer degrees of doctor of medicine or doctor of dental surgery;

(c) any other college or school incorporated under the laws of the state of New York for the purpose of teaching medicine, anatomy or surgery to those on whom the degree of doctor of medicine has been conferred;

(d) any university within the state of New York having a medical preparatory or medical postgraduate course of instruction; or

(e) any college, school or institute maintaining a mortuary science program that has either been approved by the department or holds a certificate of accreditation from an accrediting organization recognized by the department pursuant to article thirty-four of this chapter, provided, however, that such bodies remain unclaimed by any of the aforementioned institutions. Any college, school or institute maintaining a mortuary science program may only claim and utilize such bodies for anatomical and embalming instruction purposes.

2. The professors and teachers in every university, college, school or institute hereinbefore specified may receive the body of a deceased person delivered or released to the university, college, school or institute, as herein provided, for the purposes of medical, anatomical and surgical science, anatomic embalming, and study.

3. No body of a deceased person shall be delivered or released to or received by, any university, college or school or institute.

(a) if, within forty-eight hours after death it is desired for

interment or other lawful disposition by relatives and in the counties of Oneida, Onondaga, Oswego, Madison and Cortland, by relatives or friends, or,

(b) if prior to his or her death, the person shall have expressed a desire that his or her body be interred or otherwise lawfully disposed of, is carrying an identification card upon his or her person indicating his or her opposition to the dissection or autopsy of his or her body, or,

(c) if the deceased person is known to have a relative whose place of residence is known or can be ascertained after reasonable and diligent inquiry.

3-a. (a) In a city having a population of one million or more, no body of a deceased person shall be delivered or released to or received by, any university, college, school or institute, including any mortuary school unless:

(i) the person authorized to consent to make an anatomical gift with respect to the decedent under article forty-three of this chapter makes such an anatomical gift that would encompass such delivery or release;

(ii) the person authorized to control the disposition of such body under section forty-two hundred one of this article consents in writing to the delivery and release of the body of such person to the university, college, school or institute for the purpose of embalming, dissection or autopsy, provided that a chief fiscal officer of a county or a public administrator shall not be authorized to provide such consent; or

(iii) the decedent has through a lawfully executed written instrument, will or trust, consented to such delivery or release;

(b) In no event shall such delivery or release for the purpose of embalming, dissection or autopsy be authorized where the provisions of section forty-two hundred nine-a or forty-two hundred ten-c of this title apply.

(c) The person or entity having possession, charge, custody or control of the body of a deceased person under subdivision one of this section shall have no duty to locate and/or obtain the written consent from any person under this subdivision. Additionally, a chief fiscal officer of a county or a public administrator shall not be authorized to provide such

consent. In the event that such body is not delivered or released to a university, college, school or institute under this section, the body shall be released for burial or other lawful disposition consistent with this article and any other applicable provision of law.

(d) The person having lawful possession of a body under this section shall not be held liable for actions taken reasonably and in good faith upon delivery of a body pursuant to subparagraph (i) of paragraph (a) of this subdivision, presentation of a written consent pursuant to subparagraph (ii) of such paragraph, or a written instrument, will or trust pursuant to subparagraph (iii) of such paragraph.

(e) The provisions of this section shall apply notwithstanding any inconsistent provision of general, special or local law.

4. (a) A body of a deceased person shall not be delivered or released to, or received by a university, college, school or institute, if within twenty-four hours after notice of death by the person having lawful possession, charge, custody or control to the next of kin, or in the counties of Oneida, Onondaga, Oswego, Madison and Cortland to the next of kin, or friend of the deceased person such next of kin or friend shall claim such body for interment or other lawful disposition.

(b) Unless a relative or friend of the deceased person shall claim the body of the deceased person within forty-eight hours after death, or within twenty-four hours after receipt of notice of death as provided in paragraph (a) of this subdivision, the next of kin, relatives or friends, as the case may be, shall be deemed to have assented to delivery or release to, and receipt by the university, college, school or institute, of such dead body.

§ 4212. Cadavers; unclaimed; delivery to schools; procedure. 1. (a) A university, college, school or institute desiring to avail itself of the provisions of section forty-two hundred eleven of this title, shall notify the person having lawful possession, charge, custody or control of the body of the deceased person in the county where such university, college, school or institute is situated and in any other county in the state in which no medical college, school, institute or university is situated, of such desire. Thereafter, the person having possession,

charge, custody or control of the body of the deceased person shall notify the proper officer of the university, college, school or institute whenever there is any such dead body in his or her possession, charge, custody or control which may be delivered or released to and received by such university, college, school or institute, and he or she shall deliver or release same to such university, college, school or institute.

(b) Except as provided in section forty-two hundred ten of this title, no autopsy or dissection shall be performed on any such unclaimed dead body by any such person having possession, charge, custody or control of such body prior to the expiration of the fourth day after such notification or where such notification is made by mail prior to the expiration of the eighth day after such notification is postmarked.

2. It shall be the duty of the person having lawful possession, charge, custody or control of bodies of deceased persons, to keep a record in a bound book or an electronic log of any and all bodies of deceased persons thereafter coming into his or her possession, charge, custody or control and of the disposition made of said bodies, showing (a) the name of the deceased person, if known, (b) the dates of death and burial or other lawful disposition, if known, (c) the names and places of residence of relatives of the deceased person, if known, (d) the name of the person who claimed the body of the deceased person for interment or other lawful disposition, (e) the name of the university, college, school or institute to whom the body of the deceased person was delivered or released, and (f) the opposition of the deceased to the dissection or autopsy of his or her body as indicated by an identification card carried upon his or her person. This record book or electronic log shall be open to the inspection of the officers and agents of universities, colleges, schools or institutes entitled to receive bodies of deceased persons. Any electronic log kept pursuant to this subdivision shall preserve a record of any addition, deletion or change made in such log.

3. If two or more universities, colleges, schools or institutes are entitled to receive bodies of deceased persons under the provisions of this article and shall be given notice as herein provided, they shall

receive the same in proportion to the number of matriculated students in each university, college, school or institute who are pursuing courses of study in anatomy and surgery at the time of making the apportionment.

§ 4213. Cadavers; delivery to relatives or friends. 1. In the counties of Oneida, Onondaga, Oswego, Madison and Cortland, a friend who claims the body of a deceased person for interment or other disposition may be required by the person having lawful possession, charge, custody or control of it to present an affidavit stating (a) that such claimant is a friend; (b) the facts and circumstances upon which the claim that he is such friend is based; and (c), that he will bear the expense of such interment or other lawful disposition. If such claimant shall refuse to make such affidavit the body shall not be delivered to him but he shall forfeit his claim and right to same. The expense of such affidavit, if required, shall be paid by the person requiring the affidavit.

2. If the body of a deceased person is claimed for interment or other lawful disposition by a relative and in the counties of Oneida, Onondaga, Oswego, Madison and Cortland a relative or friend after delivery or release to, and receipt by a university, college, school or institute, same shall be given up and released to such relative or friend.

§ 4214. Cadavers; autopsy by order of hospital authorities. 1. The director or person having lawful control and management of any hospital in which a patient has died may order the performance of an autopsy upon the body of such deceased person, after first giving notice of the death to the next of kin of such person, unless the body is claimed or objection is made to such autopsy by the next of kin within forty-eight hours after death, or within twenty-four hours after such notice of death. In no case shall an autopsy or dissection be performed upon any body within forty-eight hours after death, unless a written consent or directive therefor has been received from the person or persons legally entitled to consent to or order such autopsy or dissection. Except as required by law, no dissection or autopsy shall be performed on the body

of any person who is carrying an identification card upon his person indicating his opposition to such dissection or autopsy.

2. In the case of an unclaimed body of a deceased person, the medical colleges, schools, institutes and universities shall have a priority claim to the said body, for the purposes of medical, anatomical or surgical science and study as provided in this article.

§ 4215. Cadavers; burial after autopsy and dissection. 1. In all cases in which a dissection has been made, the provisions of this article, requiring the burial or other lawful disposition of a body of a deceased person, and the provisions of law providing for the punishment of interference with or injuries to it, apply equally to the remains of the body after dissection as soon as the lawful purposes of such dissection have been accomplished.

2. In all cases in which an autopsy or dissection has been made of an unclaimed body, the provisions of this article requiring the burial or other lawful disposition of the body of a deceased person and punishing, interference with or injuries to it, shall apply equally to the remains of such body as soon as the lawful purposes of such autopsy or dissection have been accomplished, except that the persons having possession of the body may, in their discretion, cause it to be either buried or cremated, or may retain parts of such body for scientific purposes.

§ 4216. Body stealing. A person who removes the dead body of a human being, or any tissue, organ or part thereof from a grave, vault, or other place, where the same has been buried, or from a place where the same has been deposited while awaiting burial, without authority of law, with intent to sell the same, or for the purpose of dissection, or for the purpose of procuring a reward for the return of the same, or from malice or wantonness, is guilty of a class D felony.

§ 4217. Receiving stolen body of a human being. A person who purchases, or receives except for the purpose of burial, the dead body of a human being, or any tissue, organ, or part thereof, knowing that the same has been removed contrary to section forty-two hundred sixteen of this title, is guilty of a misdemeanor.

§ 4218. Opening graves. A person who opens a grave or other place of interment, temporary or otherwise, or a building wherein the dead body of a human being is deposited while awaiting burial, without authority of law, with intent to remove the body, or any tissue, organ or part thereof, for the purpose of selling it or demanding money for the same, or for the purpose of dissection, or from malice or wantonness, or with intent to steal or remove the coffin or any part thereof, or anything attached thereto, or any vestment, or other article interred, or intended to be interred with the dead body, is guilty of a class D felony.

§ 4219. Arresting or attaching a dead body of a human being. A person who arrests or attaches the dead body of a human being upon any debt or demand whatever, or detains or claims to detain it for any debt or demand, or upon any pretended lien or charge, is guilty of a misdemeanor.

§ 4220. Disturbing funerals. A person who, without authority of law, obstructs or detains any persons engaged in carrying or accompanying the dead body of a human being to a place of burial, is guilty of a misdemeanor.

§ 4221. Removal of eyes and/or parts thereof after death. If any donation, authorization or consent made pursuant to section forty-three hundred three of this article or dissection made pursuant to subdivision three of section forty-two hundred ten of this article relates to the removal of a deceased person's eyes and/or parts thereof, the individual

or agency authorized to remove such eyes and/or parts thereof may permit such removal to be made by a medical student, technician or nurse.

§ 4222. Removal of corneal tissue for transplant and pituitary gland tissue for the extraction of growth hormone. 1. Upon request from a general hospital or medical center for corneal tissue for transplant or pituitary gland tissue for extraction of growth hormone, the coroner or medical examiner may then request or authorize an agent to request from the authorized person under the conditions established in subdivision two of section forty-three hundred one of this chapter, the authorization, which may be oral or written according to law, to perform the removal. Upon receiving such authorization, the coroner or medical examiner shall authorize the supply of such corneal tissue or pituitary gland tissue upon the following conditions:

a. The body of the decedent is under the jurisdiction of the coroner or medical examiner authorizing the removal of the corneal tissue or pituitary gland tissue.

b. Such removal does not conflict with decedent's religious or other views.

c. The removal of the cornea for transplant or the pituitary gland for extraction of growth hormone will not interfere with the subsequent course of an investigation or autopsy.

d. The removal of the corneal tissue or the pituitary gland tissue will not alter the post mortem facial appearance of the decedent.

2. The coroner or medical examiner authorizing the removal of corneal tissue or the pituitary gland tissue pursuant to the provisions of this section shall not be held liable in a civil action for damages by any person specified by subdivision two of section forty-three hundred one of this chapter, for such removal where after the exercise of due diligence such coroner or medical examiner obtained authorization from any person specified by subdivision two of section forty-three hundred

one of this chapter.

3. Except where an anatomical gift has previously been requested or authorized, upon the request of a tissue bank or storage facility as defined in section forty-three hundred of this chapter, the coroner or medical examiner may then provide the name of the decedent under his jurisdiction and the name of the decedent's spouse or other persons authorized to execute an anatomical gift in accordance with the provisions of section forty-three hundred one of this chapter.

ARTICLE 43

ANATOMICAL GIFTS

Section 4300. Definitions.

- 4301. Persons who may execute an anatomical gift.
- 4302. Uses and dispositions of anatomical gifts.
- 4303. Manner of executing anatomical gifts.
- 4304. Delivery of document of gift.
- 4305. Amendments or revocation of the gift.
- 4306. Rights and duties at death.
- 4306-a. Advanced directives and health care proxies.
- 4306-b. Withdrawal of life-sustaining treatment.
- 4307. Prohibition of sales and purchases of human organs.
- 4308. Prohibition on charging a fee to a donor's estate.
- 4309. Application.
- 4310. New York state donate life registry for organ, eye and tissue donations.

§ 4300. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Anatomical gift" or "gift" means a donation of a whole body or part of a human body, to take effect after the donor's death, for the purpose of transplantation, therapy, research or education.

2. "Decedent" means a deceased individual of any age whose body or

part is or may be the source of an anatomical gift. The term includes a stillborn infant and, subject to restrictions imposed by law other than this article, a fetus.

3. "Disinterested witness" means a witness other than the spouse, domestic partner, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or a close friend, or another adult who is related to the decedent by blood, marriage, or adoption.

4. "Document of gift" means an organ donor card, whole body donor card, driver's license authorization to make an anatomical gift, pursuant to paragraph (a) of subdivision one of section five hundred four of the vehicle and traffic law, authorization to make an anatomical gift pursuant to any of the methods in subdivision five of section forty-three hundred ten of this article, or any other written authorization for an anatomical gift. The term "document of gift" includes a statement on a driver's license, identification card, enrollment in a donor registry, or any other anatomical gift document valid pursuant to the laws of this or any other state or of any document of gift valid pursuant to the laws of any other country appearing on a list of countries maintained by the commissioner for such purpose and published on the department's website.

5. "Domestic partner" has the same meaning as described in subdivision seven of section twenty-nine hundred ninety-four-a of this chapter.

6. "Donee" means an individual or entity authorized to accept an anatomical gift pursuant to section forty-three hundred two of this article.

7. "Donor" means an individual whose body or part is the subject of an anatomical gift.

8. "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes

or portions of human eyes.

9. "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

10. "Hospital" means a hospital licensed, accredited, or approved under the laws of any state and includes a hospital operated by the United States Government, a state, or a subdivision thereof, although not required to be licensed under state laws.

11. "Non-transplant anatomic bank" means any person or facility that solicits, retrieves, performs donor selection and/or testing, preserves, transport, allocates, distributes, acquires, processes, stores, or arranges for the storage of non-transplant anatomic parts, including whole bodies, body segments, organs, or tissues from living or deceased donors, for education and/or research purposes specifically authorized by section forty-three hundred two of this article. The following shall not constitute a non-transplant anatomic bank:

(a) Any person or entity that stores non-transplant anatomic parts, except whole bodies and body segments, solely for purposes of research and/or education conducted by such person; provided the person or entity maintains on its premises a properly executed anatomical gift consent document, and

(i) such person or entity is a legal donee pursuant to section forty-three hundred two of this article and obtains all organs/tissues from a tissue bank or non-transplant anatomic bank licensed by the department; or

(ii) is a general hospital conducting pathology services or research on non-transplant anatomic parts including whole bodies, recovered from within the facility from a living or deceased source;

(b) Any person or entity whose activities within the state of New York are limited to distribution of non-transplant anatomic parts to a tissue bank or non-transplant anatomic bank licensed by the department;

(c) Any person or entity that uses prepared slides and/or human-derived stem cell lines for purposes of education and/or research; and

(d) An employee of the federal government, provided an anatomical gift consent document has been executed in accordance with section forty-three hundred one of this article.

12. "Organ" shall have the same definition as in article forty-three-B of this chapter, but shall not be applied to heart valves for the purposes of this article.

13. "Organ procurement organization" means a person designated by the secretary of the United States Department of Health and Human Services as an organ procurement organization.

14. "Parent" means a parent whose parental rights have not been terminated.

15. "Part" of a body means and includes organs, tissues, eyes, bones, arteries, blood, other fluids and other portions of a human body, and "part" includes "parts". The term does not include the whole body.

16. "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

17. "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice under the laws of any state.

18. "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

19. "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

20. "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a

timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

21. "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

22. "Refusal" means a record created under section forty-three hundred five of this article that expressly states an intent to bar other persons from making an anatomical gift.

23. "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

24. "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to solicit, retrieve, perform donor selection and/or testing, preserve, transport, allocate, distribute, acquire, process, store or arrange for the storage of human tissues for transplantation, transfer, therapy, artificial insemination or implantation, including autogeneic procedures.

25. "Whole body" means the intact corporeal remains of an individual after the time of death.

26. "Whole body donor card" means a card or other writing indicating the donor's authorization to make an anatomical gift of a whole body to a non-transplant anatomic bank or other donee for purposes of education or research.

§ 4301. Persons who may execute an anatomical gift. 1. (a) Any individual of sound mind and eighteen years of age or more may make an anatomical gift to take effect upon their death for any purpose specified in section forty-three hundred two of this article, limit an anatomical gift to one or more of those purposes, or refuse to make an anatomical gift. In any case where the donor has a properly executed

document of gift authorization for donation shall not be rescinded or amended by any other person except upon a showing that the donor revoked the authorization pursuant to section forty-three hundred five of this article.

(b) Any person who is sixteen or seventeen years of age and of sound mind may make an anatomical gift to take effect upon their death for any purpose specified in section forty-three hundred two of this article, limit an anatomical gift to one or more of those purposes, or refuse to make an anatomical gift. In any case where the donor has a properly executed document of gift, notice of such gift shall be provided to the donor's parents or guardians, and authorization for donation may be rescinded or amended by an objection by a parent or guardian of the donor at the time of death and prior to the recovery of any organ or tissue if the donor is less than eighteen years of age. An anatomical gift made by an individual more than sixteen years of age but less than eighteen shall otherwise not be rescinded, except upon a showing that the donor revoked the authorization pursuant to section forty-three hundred five of this article. Upon the donor reaching the age of eighteen, the donor's consent to donate his or her organs or tissue shall be regarded as consent for authorization to make an anatomical gift pursuant to paragraph (a) of this subdivision.

(c) In the absence of an express, contrary indication by the donor, an anatomical gift of a part is neither a refusal to give other parts nor a limitation on an individual's ability to make an anatomical gift under subdivision two of this section.

2. (a) In the absence of a gift made by the donor under subdivision one of this section, and in the absence of actual notice of contrary indications by the decedent, including religious or moral objections, an anatomical gift of the decedent's body may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed, for any purpose specified in section forty-three hundred two of this article:

(i) the person designated as the decedent's health care agent under article twenty-nine-C of this chapter, subject to any written statement in the health care proxy form,

(ii) the person designated as the decedent's agent in a written

instrument under article forty-two of this chapter, subject to any written statement in the written instrument,

(iii) the spouse, if not legally separated from the patient, or the domestic partner,

(iv) a son or daughter eighteen years of age or older,

(v) either parent,

(vi) a brother or sister eighteen years of age or older,

(vii) an adult grandchild of the decedent,

(viii) a grandparent of the decedent,

(ix) a guardian of the person of the decedent at the time of his or her death,

(x) a close friend as defined in subdivision four of section twenty-nine hundred ninety-four-a of this chapter, or

(xi) any other person authorized or under the obligation to dispose of the body.

(b) If there is more than one member of a class listed in subparagraph (iv), (vi), (vii), (viii), or (x) of paragraph (a) of this subdivision entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or person knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

3. An anatomical gift may not be made by a person listed in subdivision two of this section if:

(a) a person in a prior class is reasonably available;

(b) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent, including that an anatomical gift is contrary to the decedent's religious or moral beliefs.

4. Any gift by a person designated in subdivision two of this section shall be by a document signed by him or her or made by his or her telegraphic, recorded telephonic, or other recorded message. Where a gift is made under this subdivision, either: (a) the authorizing party shall indicate in the document or message that he or she has no actual notice of contrary indications by the decedent and no reason to believe that an anatomical gift is contrary to the decedent's religious or moral

beliefs; or (b) an agent of the organ procurement organization or of the donee shall make reasonable efforts to inquire of the authorizing party or otherwise determine that the authorizing party has no actual notice of contrary indications by the decedent and no reason to believe that an anatomical gift is contrary to the decedent's religious or moral beliefs.

5. The donee shall not accept the gift under the following circumstances:

(a) the donee has actual notice of contrary indication by the decedent;

(b) where an anatomical gift is not properly made pursuant to this section; or

(c) the donee has reason to believe that an anatomical gift is contrary to the decedent's religious or moral beliefs.

6. A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of gift for the purposes intended.

7. The rights of the donee created by the gift are paramount to the rights of others except as provided by section forty-three hundred eight of this article.

8. The person who documents the making, amending or revoking of an anatomical gift, acting reasonably and in good faith in accordance with this article, may accept an anatomical gift under this article made by a person who represents that he or she is entitled to consent to the donation.

§ 4302. Uses and dispositions of anatomical gifts. 1. All anatomical gifts made under this article may be made to the following persons named in the document of gift:

(a) a hospital; accredited medical school, dental school, college or university; organ procurement organization; non-transplant anatomic bank; or other appropriate person, for research or education;

(b) subject to the provisions of subdivision two of this section, an individual designated by the person making the anatomical gift if the individual is the recipient of that part; if an anatomical gift to an individual under this paragraph cannot be transplanted into the individual, the part passes in accordance with subdivision six of this section in the absence of an express, contrary indication by the authorizing party making the anatomical gift; or

(c) an eye bank or tissue bank.

2. If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in subdivision one of this section, but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(a) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(b) If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(c) If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(d) If the part is an organ, eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

3. For the purposes of subdivision two of this section, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

4. If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in subdivision one of this section and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subdivision six of this section.

5. If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor", "organ donor" or "body donor", or a statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subdivision six of this section.

6. For purposes of subdivisions four, five and paragraph (b) of subdivision one of this section, the following rules apply:

(a) If the part is an eye, the gift passes to the appropriate eye bank.

(b) If the part is tissue, the gift passes to the appropriate tissue bank.

(c) If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

7. An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under paragraph (b) of subdivision one of this section, passes to the organ procurement organization as custodian of the organ.

8. If a prospective donor has been referred to a procurement organization or tissue bank pursuant to state or federal law, and the procurement organization has determined that the gift is medically unsuitable for transplant, or to the extent that a non-transplant anatomical gift may still be honored after a gift has been made pursuant to a superseding document of gift, then the procurement organization shall make reasonable efforts to determine whether the donor has previously made a gift of his or her body or parts for education or research, and the procurement organization informed of such gift shall notify the non-transplant anatomic bank of the gift consistent with the donor's intent.

9. If an anatomical gift does not pass pursuant to subdivisions one, two, three, four, five, six or seven of this section or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under

obligation to dispose of the body or part.

10. A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section forty-three hundred one or forty-three hundred five of this article or if the person knows that the decedent made a refusal under section forty-three hundred one of this article that was not revoked. For purposes of this subdivision, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

11. Except as otherwise provided in paragraph (b) of subdivision one of this section, nothing in this section affects the allocation of organs for transplantation or therapy.

§ 4303. Manner of executing anatomical gifts. 1. A gift of all or part of the body under this article may be made by will. The gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

2. A gift of all or part of the body under this article may also be made by document other than a will. The gift becomes effective upon the death of the donor. The document, which may be a card designed to be carried on the person, must be signed by the donor. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid.

3. The gift may be made either to a specified donee or without specifying a donee. If the latter, the gift may be accepted by and utilized under the direction of the attending physician upon or following death. If the gift is made to a specified donee who is not available at the time and place of death, the attending physician upon or following death, in the absence of any expressed indication that the

donor desired otherwise, may accept the gift as donee. The physician who becomes a donee under this subdivision shall not participate in the procedures for removing or transplanting a part.

4. Subject to the prohibitions in subdivision two of section four thousand three hundred six the donor may designate in his will, card or other document of gift the surgeon or physician to carry out the appropriate procedures. In the absence of a designation, or if the designee is not available, the donee or other person authorized to accept the gift may employ or authorize any surgeon or physician for the purpose.

§ 4304. Delivery of document of gift. If the gift is made by the donor to a specified donee, the will, card or other document or a copy of the executed document, may be delivered to him or her to expedite the appropriate procedures immediately after death; however delivery is not necessary to the validity of the gift. On request of an interested party upon or after the donor's death, the person in possession shall produce the document for examination.

§ 4305. Amendments or revocation of the gift. 1. An individual who has created a document of gift may only amend or revoke his or her gift by:

(a) a record signed, subsequently to the creation of the document of gift by:

(i) such individual;

(ii) another person authorized to make the anatomical gift on behalf of such individual; or

(iii) another person acting at the direction of such individual or other person authorized to make the anatomical gift if such individual is unable to sign; or

(b) an oral statement of revocation, subsequent to the creation of the gift, made by such individual in the presence of two persons, at least one of whom is a disinterested witness; or

(c) a later-executed document of gift made by such individual that amends or revokes a previous anatomical gift or portion of an anatomical

gift either expressly or by inconsistency; or

(d) a statement during a terminal illness or injury addressed to an attending physician and communicated to the donee made by such individual; or

(e) a signed card or document, found on such individual's person or in such individual's effects; or

(f) such individual's will, created subsequently to the creation of the document of gift, whether or not the will is admitted to probate or invalidated after such individual's death.

2. (a) Subject to paragraphs (b) and (c) of this subdivision, a person authorized to make an anatomical gift on behalf of another individual pursuant to subdivision two of section forty-three hundred one of this article may revoke or amend such gift by:

(i) a record signed by that individual; or

(ii) an oral statement of revocation, subsequent to the creation of the document of gift, made by that individual in the presence of two persons, at least one of whom is a disinterested witness; or

(iii) a later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift made by that individual, either expressly or by inconsistency.

(b) If more than one member of a class listed in subparagraph (iv), (vi), (vii), (viii), or (x) of paragraph (a) of subdivision two of section forty-three hundred one of this article is reasonably available, a gift made pursuant to subdivision two of section forty-three hundred one of this article shall be amended or revoked only if a majority of the reasonably available members agree.

(c) An amendment or revocation is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

3. Any document of gift may be revoked in the manner set out in subdivision one or two of this section or by destruction, cancellation, or mutilation of the document and all executed copies thereof.

4. Any gift made by a will may be revoked or amended in the manner provided for revocation or amendment of wills or as provided in subdivision one of this section.

5. In the absence of contrary indications by the donor, a revocation or amendment of an anatomical gift is not a refusal to make another anatomical gift not otherwise prohibited by the revocation or amendment, either by the prospective donor or another person specified in subdivision two of section forty-three hundred one of this article.

§ 4306. Rights and duties at death. 1. The donee may accept or reject the gift. If the donee accepts a gift of the entire body, the donee may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If the gift is of a part of the body, the donee upon the death of the donor and prior to embalming, may cause the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the surviving spouse, next of kin, or other persons under obligation to dispose of the body.

2. When a donor is determined dead based on irreversible cessation of circulatory and respiratory functions, the time of death shall be certified by a physician. Such physician may not participate in the procedure to remove or transplant the body part. In all other cases the time of death shall be certified by the physician who attends the donor at his death and one other physician, neither of whom shall participate in the procedure for removing or transplanting the part.

3. (a) (i) A person who acts in good faith in accord with the terms of this article or with the anatomical gift laws of another state, is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his or her act.

(ii) A person who acts in good faith in accord with the anatomical gift laws of another country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his or her act provided that:

(A) such country has anatomical gift laws similar in requirements and effects to the anatomical gift laws of this state;

(B) such country appears on a list of such countries promulgated as a regulation by the department for such purpose; and

(C) such country appeared on such list at the time of such act.

(b) A person who documents the making, amending or revoking of an anatomical gift, acting reasonably and in good faith in accordance with this article, may accept an anatomical gift under this article made by a person who represents that the person is an authorized person under section forty-three hundred one of this article and is entitled to consent to the donation.

(c) An entity under section forty-three hundred two or forty-three hundred ten of this article or a health care professional, or an agent or employee thereof, who or which documents, records, recovers, procures, obtains, or utilizes an organ or tissue in reasonable and good faith reliance on information provided to or contained in the New York state donate life registry shall not be liable in any civil or criminal action or proceeding for action based on such reliance.

4. Any employee or agent of an organ procurement organization, eye bank or tissue bank acting pursuant to this article shall be held to the same standard of confidentiality as that imposed on employees of a hospital.

§ 4306-a. Advanced directives and health care proxies. 1. If a prospective donor in a hospital has a declaration or advance health care directive and terms of the declaration, directive or proxy document concerning life-sustaining treatment are in conflict with the express or implied terms of a potential anatomical gift with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy, the prospective donor's attending physician and the prospective donor shall confer to resolve the conflict. For purposes of this section, an advance directive shall mean a written or oral instruction by the adult patient relating to the provision of health care to the patient when an adult becomes incapacitated, including but not limited to a health care proxy, a

consent to the issuance of an order not to resuscitate or other orders for life-sustaining treatment recorded in a patient's medical record, or a legally-recognized statement of wishes or beliefs.

2. If such prospective donor is incapable of resolving the conflict, and the patient in such declaration, directive, or proxy document did not expressly reject being a donor, then the health care proxy acting under the prospective donor's declaration, directive, or proxy or, if none, a surrogate authorized to make health care decisions on behalf of the patient, in accordance with the provisions of article twenty-nine-CC of this chapter, shall act for the patient to resolve the conflict.

3. Such conflict must be resolved expeditiously. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor described in subdivision two of section forty-three hundred one of this article. Before resolution of the conflict, measures necessary to ensure the medical suitability of the part may not be withheld or withdrawn from the patient if withholding or withdrawing the measures is not contraindicated by appropriate end-of-life care.

§ 4306-b. Withdrawal of life-sustaining treatment. This section applies in cases where a prospective donor who has made an anatomical gift or whose donation status has not been ascertained is in a hospital. The hospital shall not withdraw any measures that are necessary to maintain the medical suitability of the part until the procurement organization has had the opportunity to advise the applicable persons as set forth in section forty-three hundred one of this article of the option to make an anatomical gift, has documented or acted upon that decision, or has ascertained that the individual expressed a contrary intent. The procurement organization shall act expeditiously with respect to its responsibilities under this section.

§ 4307. Prohibition of sales and purchases of human organs. 1. It

shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer for valuable consideration any part for use in human transplantation. The term "valuable consideration" does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a part or the expenses of travel, housing, and lost wages incurred by the donor of a human part in connection with the donation of the part or living donation. Any person who violates this section shall be guilty of a class E felony.

2. For the purposes of this section, the donation of a kidney or other organ from a live donor for transplantation into an individual conditioned upon the donation and transplantation of a similar organ into an individual specified by the donor shall not, in and of itself, be considered to be "valuable consideration" provided that such donation and transplant are performed in accordance with other applicable laws, rules and regulations, including any specific rules and regulations the commissioner may adopt, with the advice and consent of the transplant council, with respect to such conditional donations. No individual may make a donation conditioned upon the race, color, creed, national origin or religious affiliation of the recipient, and no hospital, organ procurement organization, tissue bank, physician or other professional may participate in the performance of any procedure or otherwise facilitate the donation and/or transfer of organs and/or tissue conditioned on such factors.

§ 4308. Prohibition on charging a fee to a donor's estate.

Notwithstanding any other provision of law, no physician, hospital or other health care provider may charge the donor's estate, family or insurer for any cost incurred in testing or removing a human organ or tissue from a donor and such charge shall be void and unenforceable.

§ 4309. Application. The provisions of this article shall not be deemed to supersede or affect the provisions of the public health law relating to the functions, powers and duties of coroners, coroner's

physicians or medical examiners.

§ 4310. New York state donate life registry for organ, eye and tissue donations. 1. The department shall establish an organ, eye, and tissue donor registry, which shall be called and be referred to as the "donate life registry", which shall provide a means to make and register a gift of organs, eyes and tissues to take place after death pursuant to this article. The donate life registry shall contain a listing of all donors who have declared their consent to make an anatomical gift.

2. The commissioner may enter into a multi-year contract for the operation and promotion of the donate life registry subject to such terms and conditions as may be contained within such contract with a not-for-profit organization that has experience working with organ, eye and tissue procurement organizations, has expertise in conducting organ, eye and tissue donor promotional campaigns, and is affiliated with the organ, eye and tissue donation community throughout the state. The contractor may subcontract as needed for the effective performance of the contract. All such subcontractors and the terms of such subcontracts shall be subject to approval by the commissioner. Any applicable state agency, including, but not limited to, the department, the department of motor vehicles and the board of elections, shall cooperate in the collection and transfer of registrant data to the donate life registry.

3. The duties of the contractor shall include, but not be limited to, the following:

(a) the development, implementation and maintenance of the donate life registry that includes online, mailed and other forms of organ, eye and tissue donor registration, verification, amendment and revocation;

(b) preparation and submission of a plan to encourage organ, eye and tissue donation through education and marketing efforts and other recommendations that would streamline and enhance the cost-effective operation of the donate life registry;

(c) provision of written or electronic notification of registration in the donate life registry to an individual enrolling in the donate life registry; provided, however, that written in-person or electronic

notifications shall be utilized wherever possible as methods for fulfillment of the purposes of this paragraph; and

(d) preparation and submission of an annual written report to the department. Such report shall include:

(i) a performance matrix including the number of registrants on the donate life registry and an analysis of the registration rates, including but not limited to, location, method of registration, demographic, and state comparisons;

(ii) the characteristics of registrants as determined from the donate life registry information;

(iii) the annual dollar amount of voluntary contributions received by the contractor for the purposes of maintaining the donate life registry and/or educational and promotional campaigns and initiatives;

(iv) a description of the promotional campaigns and initiatives implemented during the year; and

(v) accounting statements of expenditures for the purposes of maintaining the donate life registry and promotional campaigns and initiatives.

4. (a) For the period April first, two thousand fourteen through March thirty-first, two thousand fifteen, payments to the contractor shall be paid by the department.

(b) For the period beginning April first, two thousand fifteen and thereafter, payments to the contractor shall be paid by the department from funds available for these purposes, including, but not limited to, the funds deposited into the life pass it on trust fund pursuant to section ninety-five-d of the state finance law.

(c) In addition, the contractor may receive and use voluntary contributions.

5. * (a) Such organ, eye and tissue registration of consent to make an anatomical gift can be made through: (i) indication made on the application or renewal form of a driver's license, (ii) indication made on a non-driver identification card application or renewal form, (iii) indication made on a voter registration form pursuant to subdivision five of section 5-210 of the election law, (iv) indication made on the application for, or manual renewal application by an account holder of,

health care coverage offered through the NY State of Health, the official Health Plan Marketplace, (v) enrollment through the donate life registry website, (vi) paper enrollment submitted to the donate life registry, (vii) indication made on the application or renewal form of a hunting, fishing or trapping license issued pursuant to title seven of article eleven of the environmental conservation law, (viii) indication made on transactions administered by the office of temporary and disability assistance through the mybenefits.ny.gov website, or any such successor website; (ix) indication made on applications, renewals or related transactions for college financial aid, grants, or scholarships offered or administered through any website maintained by the higher education services corporation; (x) indication made by an insured and/or applicant for insurance during enrollments, renewals, and the initial process for an insured in setting up an online member service portal with their insurer for accident and health insurance policies and contracts issued pursuant to article forty-four of this chapter, article forty-two of the insurance law, or article forty-three of the insurance law, excepting renewals made through the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of this paragraph and paragraph (v) of subdivision one of section two hundred six of this chapter; and provided, however, that nothing in this section shall apply to the medical assistance program under title eleven of article five of the social services law; or (xi) through any other method identified by the commissioner. The department shall establish a means by which to register the consent given by individuals who are sixteen or seventeen years of age in the donate life registry, and shall make registration available by any of the methods provided in subparagraphs (i), (ii), (iii), (iv), (v), (vi), (vii), (viii), (ix), (x) and (xi) of this paragraph.

* NB Effective until December 21, 2026

* (a) Such organ, eye and tissue registration of consent to make an anatomical gift can be made through: (i) indication made on the application or renewal form of a driver's license, (ii) indication made on a non-driver identification card application or renewal form, (iii) indication made on a voter registration form pursuant to subdivision five of section 5-210 of the election law, (iv) indication made on the

application for, or manual renewal application by an account holder of, health care coverage offered through the NY State of Health, the official Health Plan Marketplace, (v) enrollment through the donate life registry website, (vi) paper enrollment submitted to the donate life registry, (vii) indication made on the application or renewal form of a hunting, fishing or trapping license issued pursuant to title seven of article eleven of the environmental conservation law, (viii) indication made on transactions administered by the office of temporary and disability assistance through the mybenefits.ny.gov website, or any such successor website; (ix) indication made on applications, renewals or related transactions for college financial aid, grants, or scholarships offered or administered through any website maintained by the higher education services corporation; (x) indication made by an insured and/or applicant for insurance during enrollments, renewals, and the initial process for an insured in setting up an online member service portal with their insurer for accident and health insurance policies and contracts issued pursuant to article forty-four of this chapter, article forty-two of the insurance law, or article forty-three of the insurance law, excepting renewals made through the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of this paragraph and paragraph (v) of subdivision one of section two hundred six of this chapter; and provided, however, that nothing in this section shall apply to the medical assistance program under title eleven of article five of the social services law; (xi) transactions conducted through the patient-facing portal of an individual's electronic health record; or (xii) through any other method identified by the commissioner. The department shall establish a means by which to register the consent given by individuals who are sixteen or seventeen years of age in the donate life registry, and shall make registration available by any of the methods provided in subparagraphs (i), (ii), (iii), (iv), (v), (vi), (vii), (viii), (ix), (x), (xi) and (xii) of this paragraph.

* NB Effective December 21, 2026

(b) * (i) Where required by law for transactions described in subparagraphs (i), (ii), (iv), (vii), (viii), (ix), (x), (xi) and (xii) of paragraph (a) of this subdivision, the commissioner shall ensure, in consultation with the head of any agency required to implement such

transaction, that space is provided on any required form so that the applicant shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

* NB Effective until December 21, 2026

* (i) Where required by law for transactions described in subparagraphs (i), (ii), (iv), (vii), (viii), (ix), (x) and (xi) of paragraph (a) of this subdivision, the commissioner shall ensure, in consultation with the head of any agency required to implement such transaction, that space is provided on any required form so that the applicant shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

* NB Effective December 21, 2026

(ii) The commissioner shall not maintain records of any person who checks "skip this question". Except where the application is made in person or electronically, failure to check a box shall not impair the validity of an application, and failure to check "yes" or checking "skip this question" shall not be construed to imply a wish not to donate. In the case of an applicant under eighteen years of age, checking "yes" shall not constitute consent to make an anatomical gift or registration in the donate life registry, except as otherwise provided pursuant to the provisions of paragraph (b) of subdivision one of section forty-three hundred one of this article. Where an applicant has previously consented to make an anatomical gift or registered in the donate life registry, checking "skip this question" or failing to check a box shall not impair that consent or registration.

(c) Enrollment or amendment or revocation through the donate life registry website through any of the means listed in this subdivision may be signed by electronic signature, in accordance with the provisions of article three of the state technology law, supported by the use of

suitable mechanisms including unique identifiers to provide confidence in the identity of the person providing the electronic signature. The registration shall take effect upon the provision of written or electronic notice of the registration to the individual enrolling in the donate life registry and the registry's entry of the individual's enrollment data in the registry; provided, however, that written in-person or electronic notifications shall be utilized wherever possible as methods for fulfillment of the purposes of this paragraph.

(d) Amendments or revocations from the donate life registry shall be made by the following, subject to the requirements of the commissioner:

(i) registrants submitting an amendment or revocation in writing to the donate life registry; or

(ii) registrants submitting an amendment or revocation electronically through the donate life registry website.

(e) Removal from the donate life registry shall not be deemed a refusal of any other or future anatomical gift.

(f) The donate life registry shall provide individuals enrolled the opportunity to specify which organs, eyes and tissues they want to donate and if the donation may be used for transplantation, research, or both.

6. An individual registered in the donate life registry before July twenty-third, two thousand eight shall be deemed to have expressed intent to donate, until and unless he or she files an amendment to his or her registration or a new registration expressing consent to donate.

7. (a) The donate life registry shall be maintained in a manner that allows immediate access to organ, eye and tissue donation records twenty-four hours a day, seven days a week to the contractor, the department, federally designated organ procurement organizations, licensed eye and tissue banks, and such other entities which may be approved by the department for access. Access shall be available to registrants to confirm the accuracy and validity of their registration and to amend or revoke their registration, subject to reasonable procedures to verify identity.

(b) Access to the donate life registry shall have security measures set forth in the contract to protect the integrity of the identifiable

data in the donate life registry, which may only be accessed by the parties described in paragraph (a) of this subdivision and only for the purposes of determining donor status at or near the time of death of an individual, by the department for any purpose, by the contractor only for purposes of quality assessment and improvement, technical support and donor services, or by individual registrants for the purposes of confirming the accuracy and validity of their registration or making, amending or revoking their registration.

(c) De-identified information may be accessed by the entities listed in paragraph (a) of this subdivision or their designees for purposes of analysis, promotion, education, quality improvement and technical support for the donate life registry. The information contained in the registry shall not be released to any person except as expressly authorized by this section, solely for the purposes so authorized.

8. The commissioner is authorized to promulgate rules and regulations necessary to implement the provisions of this section.

9. An interagency work group, composed of the commissioner, the commissioner of the department of motor vehicles, a chair of the board of elections, or their designees, and such other individuals as may be designated by the commissioner, shall be established to meet with the contractor annually and as needed to review the status of the donate life registry, to examine the steps that might be taken by state agencies to enhance its performance and to make recommendations to the contractor.

ARTICLE 43-A

ANATOMICAL GIFT DUTIES OF HOSPITALS AND PROCUREMENT ORGANIZATIONS

Section 4351. Duties of hospital administrators, organ procurement organizations, eye banks or tissue banks.

§ 4351. Duties of hospital administrators, organ procurement organizations, eye banks or tissue banks. 1. (a) When the death of a

person in a hospital has occurred or is imminent, the hospital shall contact the organ procurement organization in order to make a preliminary determination of the suitability of the person for organ donation, except where not required by paragraph (c) of this subdivision. If a hospital has ascertained that the individual expressed a desire not to receive life-sustaining treatment, pursuant to section forty-three hundred six-b of this chapter, the hospital shall make the organ procurement organization aware.

(b) Where contact with the organ procurement organization is not required under criteria developed regionally by the organ procurement organization subject to the approval of such criteria by the department, the hospital shall contact the appropriate eye bank or tissue bank, except where not required by paragraph (c) of this subdivision.

(c) The organ procurement organization, in consultation with the tissue procurement providers, may issue criteria under which a hospital shall not be required to make the contact under this subdivision.

(d) All hospitals shall select at least one eye bank or tissue bank for the procurement of tissue, as defined in section forty-three hundred sixty of this chapter. A hospital shall notify the organ procurement organization of its choice of tissue procurement provider. If a hospital selects more than one eye bank or tissue bank, it may specify a rotation of referrals for purposes of tissue procurement.

2. Where the organ procurement organization, eye bank or tissue bank is contacted, it shall, in consultation with the hospital, after appropriate medical screening (which may include serological testing if applicable) determine suitability for organ, eye and tissue donation, as appropriate. Where an organ procurement organization is contacted, it shall contact the appropriate eye bank or tissue bank with respect to suitability for eye or tissue donation.

ARTICLE 43-B

ORGAN PROCUREMENT AND DONOR SUPPORT

Title 1. Organ, tissue and body parts procurement and storage (§§ 4360-4369).

2. Living organ donation (§§ 4370-4372).

TITLE 1

ORGAN, TISSUE AND BODY PARTS PROCUREMENT AND STORAGE

Section 4360. Definitions.

4361. Transplant council.

4362. Organ procurement organizations.

4363. Waiting lists for organs.

4364. Licensure of banks and storage facilities.

4365. Powers and duties of the commissioner.

4366. Enforcement.

4367. Separability.

4368. New York state gift of life medal of honor.

4369. Bone marrow registry information.

§ 4360. Definitions. The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Bank" or "storage facility" means any person or facility, which procures, stores or arranges for the storage of (a) non-transplant organs, or (b) tissue for transplantation, therapy, education, research, or fertilization purposes, including autologous procedures. An organ procurement organization shall not constitute a bank or storage facility solely by virtue of storing or arranging for the storage of heart valves, nor shall any person or entity which stores non-transplant organs or tissues solely for the purpose of research and/or education conducted by such person or entity be deemed a bank or storage facility.

2. "Controlling person" means any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said corporation, partnership, or other entity. Neither the commissioner nor any employee of the department nor any member of a local legislative body of a county or municipality, nor any county or

municipal official, shall, by reason of his or her official position, be deemed a controlling person of any corporation, partnership, or other entity, nor shall any person who serves as an employee of any corporation, partnership, or other entity be deemed to be a controlling person of such corporation, partnership, or other entity as a result of such position or his or her official actions in such position.

3. "Non-transplant organ" means an organ procured for education or research purposes.

4. "Organ" means a human kidney, heart, heart valve, lung, pancreas, liver or any other organ designated by the commissioner in regulation in consultation with the transplant council.

5. "Organ procurement organization" or "procurement organization" means a person, facility, or institution engaged in procuring organs for transplantation or therapy purposes, but does not include (a) facilities or institutions which permit procurement activities to be conducted on their premises by employees or agents of an approved organ procurement organization, or (b) facilities or consortia of facilities which conduct transplantation activities in accordance with article twenty-eight of this chapter when the organ is procured through an approved organ procurement organization, licensed bank or storage facility, or a living donor. A bank or storage facility shall not constitute an organ procurement organization solely by virtue of procuring heart valves.

6. "Person" means an individual, corporation, government or governmental subdivision or agency other than the office of mental health, business trust, estate trust, partnership or association, or any other legal entity.

7. "Principal stockholder" means any person who owns (whether of record or as beneficiary), holds or has the power to vote, ten percent or more of any class of securities issued by a corporation.

8. "Procure" or "procurement activity" means any activity which is necessary for the procurement of organs or tissue for transplantation,

research, education, therapy, fertilization, or autologous purposes including solicitation, retrieval, donor selection and testing, clinical laboratory testing, including typing, preservation, transportation, allocation, distribution, storage, and payment activities.

9. "Service area" means the geographic area of service approved by the secretary of health and human services, or, in the absence of such approval, by the department.

10. "Tissue" means a human eye, skin, bone, bone marrow, heart valve, spermatozoon, ova, artery, vein, tendon, ligament, pituitary gland or a fluid other than blood or a blood derivative.

§ 4361. Transplant council. 1. There shall be created in the department a transplant council which shall advise and make recommendations to the commissioner on matters relating to organ donation, procurement organizations, banks, and storage facilities and other issues related to the donation, procurement, storage, allocation, distribution, and transplantation of organs and tissue. The council shall consist of twenty-one members of which seven, including the chairperson, shall be appointed by the governor, seven by the temporary president of the senate and seven by the speaker of the assembly. The transplant council shall be composed of members of the general public, transplant recipients or donors or their family members, representatives of organ procurement organizations and banks or storage facilities, physicians with expertise in organ and tissue transplantation and the care of persons with end stage disease resulting from organ failure and persons with expertise in histocompatibility typing, law and ethics.

2. The terms of office of members of the transplant council shall be three years, provided, however, that of the members first appointed seven shall be appointed for terms which shall expire on December thirty-first, nineteen hundred ninety-two, seven shall be appointed for terms which shall expire on December thirty-first, nineteen hundred ninety-four and seven shall be appointed for terms which shall expire December thirty-first, nineteen hundred ninety-six. Vacancies shall be

filled by appointment in like manner for the unexpired term of such member.

3. The transplant council shall meet as frequently as its business may require, and at least twice in each year.

4. The transplant council shall enact and from time to time may amend by-laws in relation to its meetings and the transaction of its business.

5. A majority of the appointed voting membership of the transplant council shall constitute a quorum.

6. The members of the council shall receive no compensation for their services as members of the council, but each of them shall be allowed the necessary and actual expenses which are incurred in the performance of his or her duties under this article.

7. (a) The transplant council shall review existing federal law and policies, including federal regulations and the policies of the federal organ procurement and transplantation network governing organ procurement organizations and procurement activities, and make recommendations annually to the commissioner regarding state regulation of organ donation procurement organizations and activities and tissue banks and tissue procurement activities and transplantation.

(b) Prior to the commissioner's final approval and promulgation of proposed rules and regulations relating to organ donation, procurement and/or transplantation, if such rules and regulations are modified in any respect, they shall be submitted to the council in accordance with the provisions of subdivision three of section forty-three hundred sixty-five of this article. If the commissioner determines not to promulgate or amend such proposed rules and regulations as proposed by the council, the commissioner shall provide a written explanation of such determination to the council.

§ 4362. Organ procurement organizations. 1. No person shall own or operate an organ procurement organization that is principally located or

operated in New York state unless:

(a) the organization is currently designated by the secretary of health and human services as an organ procurement organization; and

(b) the organ procurement organization is operated by a not-for-profit corporation having a board of directors which meets no less than four times annually or is operated by a hospital and has an advisory board which meets no less than four times annually. At least thirty percent of the members of the board of directors or advisory board shall be members of the public not otherwise directly or indirectly affiliated with a transplant center or organ procurement organization, and not more than fifty percent shall be surgeons or physicians. Such board of directors or advisory board shall include representatives of more than one transplant center. The board of directors of an organ procurement organization operated by a not-for-profit corporation or the advisory board of an organ procurement organization operated by a hospital shall be responsible for developing and adopting the written by-laws and policies that govern the operation of the organ procurement organization. All such by-laws and policies for an organ procurement organization operated by a hospital shall be subject to approval by the board of directors of the hospital. Written policies shall include, but not be limited to: (i) policies and procedures to educate the public and health care professionals about organ donations; (ii) medical standards for donor screening and testing; (iii) policies and procedures for the distribution of organs; (iv) procedures to ensure fiscal accountability of the organ procurement organization; and (v) policies concerning any arrangements or agreements that the organ procurement organization may enter with tissue banks storage facilities or other organ procurement organizations.

2. No hospital or other facility and no physician shall permit any person to, and no person shall, procure organs for transplantation unless such person has been designated in accordance with this article or has been asked by a designated organ procurement organization to procure a specified organ.

3. The commissioner, in consultation with the transplant council, may promulgate regulations to establish standards for organ procurement

organizations regarding organ sharing among organ procurement organizations in this state. Such standards shall include policies for sera sharing or other measures to meet the needs of patients who are highly sensitized and for whom it is difficult to identify a suitable kidney due to conditions such as a blood transfusion, immunization, prior pregnancy or a previous failed kidney transplant.

§ 4363. Waiting lists for organs. 1. All organs retrieved for transplantation in New York state shall be allocated according to waiting lists developed by the organ procurement organization in the service area in which the organ is procured, provided, however, that nothing herein shall preclude the exercise of medical judgment in determining the suitability of a proposed recipient to receive a particular organ, and provided further, however, that if an organ is brought into a service area of an organ procurement organization from the service area of another organ procurement organization, the organ shall be allocated according to the waiting list developed by the organ procurement organization in the service area in which the organ is to be implanted. Nothing in this section shall prohibit:

- (a) an individual donor from designating the recipient of an organ;
- (b) organ sharing with other organ procurement organizations in accordance with federal and state standards including standards to meet the needs of patients who are highly sensitized and for whom it is difficult to identify a suitable kidney due to conditions such as a blood transfusion, immunization, prior pregnancy or a previous failed kidney transplant;
- (c) organ sharing with other organ procurement organizations in accordance with organ sharing agreements approved by the commissioner.

2. In policies and procedures for distributing organs, no organ procurement organization shall consider or give any preference to patients in a facility based upon the facility's past or present procurement performance or its past or present relationship with a donor hospital.

§ 4364. Licensure of banks and storage facilities. 1. No person shall own or operate a bank or storage facility that conducts procurement activity in New York state unless a license has been issued pursuant to this article.

2. An application for a license for a bank or storage facility shall contain the name of the operator, its officers, directors, principal stockholders, and controlling persons, a description of its organizational structure, the kind or kinds of procurement or storage services to be provided, the location and physical description of the bank or storage facility, and such other information as the department may require.

3. A license shall not be issued unless the department finds that the premises, equipment, personnel, rules and by-laws, and standards of service are fit and adequate and that the bank or storage facility will be operated in the manner required by this article.

4. Prior to approving an application for a license to operate a bank or storage facility which procures or stores tissue for transplantation or therapy purposes, the department shall consider:

(a) the applicant's ability to arrange for the acquisition and preservation of usable donated tissue within a designated geographic area of service and to arrange for the transportation of such tissue when necessary;

(b) the applicant's ability to obtain effective agreements for tissue procurement with hospitals;

(c) the applicant's ability to conduct and participate in systematic efforts, including professional and public education, to procure usable tissue from potential donors;

(d) the applicant's ability to establish and meet quality standards for the acquisition and storage of tissue;

(e) the applicant's ability to arrange for the selection and testing of donors and donated tissue, including the performance of donor selection and required laboratory tests including typing and processing;

(f) the applicant's ability to moderate and record temperature, including an adequate alarm notification system;

(g) the applicant's ability to establish a chain of custody for specimens;

(h) the applicant's ability to establish administrative, technical, and physical safeguards to protect patient records;

(i) the character and competence of the operator, its officers, directors, principal stockholders and controlling persons, including the quality of care provided through any health care entities operated or controlled by such persons; and

(j) with respect to banks and storage facilities created after the effective date of this paragraph, the existence and activities of other banks and storage facilities in the geographic area to be served by the applicant.

5. No hospital or other facility and no physician shall permit any person to procure tissue or non-transplant organs unless such person has been licensed in accordance with this article, or has been asked by a licensed bank or storage facility to procure a specified tissue or non-transplant organ. No bank or storage facility shall sell or otherwise transfer tissue for valuable consideration. Valuable consideration shall not include reasonable costs associated with the procurement, processing, storage and distribution of tissue. Nothing herein shall impair the provisions of section forty-three hundred seven of this chapter.

6. The commissioner is authorized to promulgate rules and regulations necessary to implement the provisions of this section.

§ 4365. Powers and duties of the commissioner. 1. The commissioner, in consultation with the transplant council, may promulgate regulations to establish standards for banks and storage facilities other than those owned or operated by the office of mental health. Such standards may provide for the following: the organizational structure of banks and storage facilities; the geographic scope of licensed banks and storage facilities; donor selection and solicitation practices; tissue and non-transplant organ retrieval practices; transportation practices; required clinical laboratory tests for suitable donors, recipients and

tissue; histocompatibility standards; allocation criteria; reporting requirements; record keeping requirements; accounting procedures; staff requirements; the content of agreements with hospitals from which tissues and non-transplant organs will be procured; and the content of agreements with organ procurement organizations, educational institutions, other banks and storage facilities, and other entities providing services to banks or storage facilities in connection with the procurement, storage, and distribution of tissue and non-transplant organs. The commissioner and the commissioner of mental health shall enter into a cooperative agreement to establish standards for banks and storage facilities owned or operated by the office of mental health which may include standards for donor selection and solicitation practices; tissue and non-transplant organ retrieval practices; transportation practices; reporting requirements; record keeping requirements; the content of agreements with hospitals from which tissues and non-transplant organs will be procured, and the content of agreements with other banks and storage facilities.

2. Notwithstanding any inconsistent provision of article five of this chapter, the commissioner, in consultation with the transplant council, may promulgate regulations to establish quality control standards governing tissue typing conducted by or at the request of organ procurement organizations and facilities performing transplant services. Such regulations may eliminate duplicative testing by laboratories by limiting within a service area the performance of histocompatibility matching and tissue typing services for cadaveric organ donations for transplantation in New York state.

3. At least sixty days prior to the commissioner's final approval of rules and regulations proposed pursuant to this article, other than emergency rules and regulations, the commissioner shall submit such proposed rules and regulations to the council for its review. The council shall review such rules and regulations and submit its recommendations to the commissioner within sixty days. The commissioner shall not act in a manner inconsistent with the recommendations of the council without first providing to the council a written explanation of the reasons therefor.

4. The commissioner, in consultation with the transplant council, shall promulgate regulations on the donation of ova. Such regulations shall include, but not be limited to:

(a) guidelines and procedures for obtaining fully informed consent from potential donors, including but not limited to a full disclosure of any known or potential health risks of the ova donation process;

(b) the development and distribution, in printed form and on the department's website, of informational material relating to the donation of ova;

(c) the establishment of a voluntary central tracking registry of ova donor information, as reported by banks and storage facilities licensed pursuant to this article upon the affirmative consent of an ova donor. Such registry shall provide a means for gathering and maintaining accurate information on the:

(i) number of ova and the number of times ova have been donated from a single donor;

(ii) health information of the donor at the time of the donation; and

(iii) other information deemed appropriate by the commissioner.

In addition, all such regulations shall maintain the anonymity of the donor and any resulting offspring and govern access to information maintained by the registry. Such registry shall comply with all state and federal laws and regulations related to maintaining the privacy and confidentiality of records contained within the registry; and

(d) the development of best practices and procedures, in consultation with the American college of obstetricians and gynecologists, American society for reproductive medicine and other medical organizations, for ova donation, ova retrieval, and in vitro fertilization for the protection of the health and safety of the donor.

5. The commissioner may inquire into the operation of banks and storage facilities and may conduct periodic inspections of banks and storage facilities including methods, procedures, materials, staff and equipment.

6. Organ procurement organizations, banks, storage facilities, and

other persons engaged in procurement activities shall submit, in a form prescribed by the department, periodic reports of procurement, storage and distribution activities and such other information as the commissioner may require to carry out the provisions of this article. Where available, the commissioner shall utilize information reported by organ procurement organizations to the organ procurement and transplantation network established pursuant to section three hundred seventy-two of the federal public health services act.

7. In consultation with the transplant council, the commissioner is authorized to establish subcategories of licenses based upon the tissue and non-transplant organs to be procured or stored by banks and storage facilities and the activities to be conducted and may include different standards for each subcategory of license.

8. Nothing contained within this article shall limit the authority of the council on human blood and transfusion services to adopt rules and regulations concerning blood and bone marrow in accordance with article thirty-one of this chapter.

9. The commissioner, in cooperation and consultation with the transplant council and other interested parties, shall develop and distribute, in printed form and on the department's internet website, informational materials relating to the live donation of organs and tissue, including, but not limited to:

- (a) the benefits of live organ and tissue donation;
- (b) the impact of the donation of organs or tissue on the donors' access to insurance and assistance;
- (c) the reduction in federal adjusted gross income, for state personal income tax purposes, granted to living organ and tissue donors; and
- (d) the protections and benefits granted pursuant to the living donor protection act of two thousand eighteen.

§ 4366. Enforcement. 1. The commissioner may revoke, suspend, limit or annul, a bank or storage facility license or may fine the holder thereof on proof that the license holder or one or more persons in its employ:

(a) has engaged in misrepresentation in obtaining the license or in the operation of the bank or storage facility;

(b) has engaged or attempted to engage in or represented itself as being entitled to perform any procurement or storage activity not authorized in the license;

(c) has demonstrated incompetence or has shown recurrent errors in the performance of procurement or storage activities;

(d) has been convicted of a felony.

2. No license shall be revoked, suspended, limited, or annulled or fine imposed without an opportunity for a hearing; provided, however, that a license may be temporarily suspended without a hearing for a period not in excess of sixty days upon notice to the license holder following a finding by the commissioner or his designee that the public health, safety, or welfare is in imminent danger.

(a) the commissioner or his designee shall fix a time and place for the hearing;

(b) a copy of the charges, together with a notice of the time and place of the hearing, shall be mailed to the license holder at the address of the bank or storage facility;

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

3. The supreme court may enjoin violations or threatened violations of any provisions of this article or of the rules and regulations issued thereunder. Upon request of the commissioner, the attorney general shall maintain an action in the supreme court in the name of the people of the state to enjoin any such violation.

§ 4367. Separability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section, or part thereof directly involved in the controversy in which the judgment shall have been

rendered.

§ 4368. New York state gift of life medal of honor. The governor shall establish a program for public recognition of organ, tissue and bone marrow donors and their families for their life saving contributions. The governor shall commission the design, with the advice and consent of the department and the transplant council established pursuant to section forty-three hundred sixty-one of this article, of the "New York State gift of life medal of honor". Such medal shall be awarded annually to honor the memory of all individual organ donors or the gifts of donor families. Persons who donate bone marrow shall also be eligible to be awarded the medal. The department and the transplant council shall be responsible for nominating and choosing recipients, and for overseeing and maintaining such program.

§ 4369. Bone marrow registry information. 1. The commissioner, in consultation with health care practitioners and others with expertise in bone marrow donation and transplant and with the assistance of the transplant council as appropriate, shall develop and make available information regarding bone marrow donation and registries, including but not limited to the National Marrow Donor Program "Be The Match Registry" registry and The Bone Marrow Foundation. Such information shall include, but not be limited to:

- (a) the need for bone marrow donations;
- (b) patient populations that would benefit from bone marrow donations;
- (c) how to join a bone marrow registry; and
- (d) how to acquire a free buccal swab kit from a bone marrow registry.

2. The information required by this section shall be made available on the department's website in a printable format to allow the public to access such information and for health care practitioners providing primary care to provide such information to patients who are eighteen years of age or older and under forty-five years of age who are not registered with a bone marrow registry.

TITLE 2
LIVING ORGAN DONATION

Section 4370. Definitions.

4371. Reimbursement of living donor expenses.

4372. Transplant education of patients with kidney disease or end stage renal failure.

§ 4370. Definitions. As used in this title, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Living donation" means the gift by an individual of an organ of that individual's body to be transplanted into another individual's body, the gift to be executed while the donating individual is living and with the intent that the donating individual will continue to live after the execution of the gift.

2. "Living donor" means: (a) an individual who makes a living donation; or

(b) an individual who incurs expenses as part of the living donation screening and evaluation process but that, through no decision or judgment of their own, does not become an actual living donor.

3. "Living donor expenses" means financial costs incurred by a living donor that arise due to the act of living donation and its consequences, that are subject to reimbursement under section forty-three hundred seventy-one of this title.

4. "Living donor support program" or "program" means the living donor support program established under section forty-three hundred seventy-one of this title.

5. "Paired donation" means a living donation in which the living donor's organ is incompatible with the ultimate intended recipient and the living donor's organ is transplanted into another recipient, and in

turn another living donor makes a living donation, directly or through one or more paired donations, to the ultimate intended recipient of the initial living donor.

§ 4371. Reimbursement of living donor expenses. 1. The living donor support program is hereby established in the department.

2. (a) Subject to appropriations therefor, the program shall pay the living donor expenses for living donors who are residents of the state and make a living donation in which the ultimate recipient, either directly or through paired donation is a resident of the state. The commissioner through regulations shall establish eligible living donor expenses that are eligible for reimbursement under the program which shall include at a minimum: lost wages (including demonstrated lost non-employment income) or the economic value of sick or vacation days expended; travel and lodging, child care and elder care expenses; and costs of medications and care associated with the living donation surgery that are not covered by health insurance. The total period of time related to lost wages or expended sick or vacation days shall not exceed four weeks unless special circumstances are demonstrated, such as the nature of physical labor required for the living donor's employment; provided that the total period shall in no event exceed eight weeks. The commissioner may, by regulation, impose reasonable limitations on: (i) the amount of lost wages for a living donor making an income in excess of an annual rate of one hundred twenty-five thousand dollars; or (ii) the amount of living donor expenses above fourteen thousand dollars for any single living donor; and may include additional living donor expenses including reimbursement for costs of care performed by relatives or family members of the living donor.

(b) The program shall not pay reimbursement for expenses paid or required to be paid for by any third-party payer, including wages or other expenses that were covered under paid medical leave by the living donor's employer or that are covered by other sources of reimbursement such as the federal National Living Donor Assistance Program. The program shall be the payer of last resort with respect to any benefit under the program.

(c) Living donor expenses shall be reimbursed as close in time as possible to their being incurred by the donor, including by pre-payment where practicable.

3. (a) The commissioner may contract for the administration of reimbursement under the program. Factors such as cost to the state, ease of use for the living donor, and ease of use for transplant center hospitals shall be taken into consideration when awarding such contract.

(b) The commissioner shall make regulations to implement this section.

(c) This section shall be interpreted so as not to conflict with the federal National Organ Transplant Act (42 U.S.C. 274e).

§ 4372. Transplant education of patients with kidney disease or end stage renal failure. Nephrologists and primary care providers with primary responsibility of caring for patients with chronic kidney disease stage three or four, or end stage renal disease, shall provide patients with current and evidence based printed educational materials about the progression of kidney disease and relevant prevention and treatment options, including transplantation.

ARTICLE 44

HEALTH MAINTENANCE ORGANIZATIONS

- Section 4400. Statement of policy and purposes.
4401. Definitions.
4402. Health maintenance organizations; application for certificate of authority.
4403. Health maintenance organizations; issuance of certificate of authority.
- 4403-a. Special purpose certificate of authority.
- 4403-b. Development of comprehensive health services plans.
- 4403-c. Comprehensive HIV special needs plan certification.
- 4403-d. Special needs managed care plans.
- 4403-e. Primary care partial capitation providers; partial capitation certificate of authority.
- 4403-f. Managed long term care plans.

- 4403-g. Developmental disability individual support and care coordination organizations.
- 4404. Health maintenance organizations; continuance of certificate of authority.
- 4405. Health maintenance organizations; powers.
- 4405-a. Immunizations against poliomyelitis, mumps, measles, diphtheria and rubella.
- 4405-b. Duty to report.
- 4406. Health maintenance organizations; regulation of contracts.
- 4406-a. Arbitration provisions of health maintenance organization contracts.
- 4406-b. Primary and preventive obstetric and gynecologic care.
- 4406-c. Prohibitions.
- 4406-d. Health care professional applications and terminations.
- 4406-e. Access to end of life care.
- 4406-f. Maternal depression screenings.
- 4406-g. Telehealth delivery of services.
- 4406-h. Health care facility applications.
- 4406-i. Utilization review determinations for medically fragile children.
- 4407. Health maintenance organizations; employer requirements.
- 4408. Disclosure of information.
- 4408-a. Integrated delivery systems.
- 4408-a*2. Grievance procedure.
- 4409. Health maintenance organizations; examinations.
- 4410. Health maintenance organizations; professional services.
- 4411. Construction.
- 4412. Separability.
- 4413. Savings clause.
- 4414. Health care compliance programs.
- 4416. Excess reserves of certain health maintenance organizations.

§ 4400. Statement of policy and purposes. Encouraging the expansion of health care services options available to the citizens of the state is a matter of vital state concern. Without such an expansion, increased health insurance and other benefits will continue to escalate the costs of medical care and overload the health care delivery system. The health maintenance organization concept, through which members of an enrolled population are each entitled to receive comprehensive health services for an advance or periodic charge, represents a promising new alternative for the delivery of a full range of health care services at a reasonable cost.

Accordingly, it shall be the policy of this state to expand the health care services options available, and to assure greater choice in the selection of a health care plan, by removal of legal and other impediments to the development of competitive health maintenance organizations acceptable to the public.

It is the intent of the legislature that the commissioner therefore establish a comprehensive system of authorization and regulation of health maintenance organizations in the state, as provided in this article, in order to assure that health services of good quality be provided to all citizens who choose to take advantage of that alternative to meet their health care needs. The commissioner shall cooperate with the superintendent of financial services and with other state officials and agencies which establish standards and requirements pertaining to the provision and financing of health care services in order to assure necessary, equitable and consistent state supervision of all health care systems without duplication of inspection or services.

§ 4401. Definitions. For the purpose of this article: 1. "Health maintenance organization" or "organization" means any person, natural or corporate, or any groups of such persons who enter into an arrangement, agreement or plan or any combination of arrangements or plans which propose to provide or offer, or which do provide or offer, a comprehensive health services plan.

2. "Comprehensive health services plan" or "plan" means a plan through which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge. A plan may include the provision of health care services which are covered by the organization at the election of enrollees by health care providers not participating in the plan pursuant to a contract, employment or other association to the extent authorized in section forty-four hundred six of this article; provided, however, that in no event shall an enrollee elect to have a non-participating provider serve as the enrollee's primary care practitioner responsible for supervising and coordinating the care of the enrollee.

3. "Comprehensive health services" means all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services. Such term may be further defined by agreement with enrolled populations providing additional benefits necessary, desirable or appropriate to meet their health care needs.

4. "Enrolled population" means a group of persons, defined as to probable age, sex and family composition, which receives comprehensive health services from a health maintenance organization in consideration for a basic advance or periodic charge.

5. "Superintendent" means the superintendent of financial services of the state of New York.

* 6. "Comprehensive HIV special needs plan" means a health maintenance organization certified pursuant to section forty-four hundred three-c of this article which, in addition to providing or arranging for the provision of comprehensive health services on a capitated basis, including those for which medical assistance payment is authorized pursuant to section three hundred sixty-five-a of the social services

law, also provides or arranges for the provision of HIV care to HIV positive persons eligible to receive benefits under title XIX of the federal social security act or other public programs.

* NB Repealed March 31, 2030

* 7. "HIV Center of excellence" is defined as a health care facility certified to operate under article twenty-eight of this chapter that offers specialized treatment expertise in HIV care services as defined by the commissioner.

* NB Repealed March 31, 2030

8. "Special needs managed care plan" shall mean a combination of persons natural or corporate, or any groups of such persons, or a county or counties, who enter into an arrangement, agreement or plan, or combination of arrangements, agreements or plans, to provide health and behavioral health services to enrollees with significant behavioral health needs.

9. "Medically fragile child" means an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria (a) is technologically dependent for life or health sustaining functions, (b) requires a complex medication regimen or medical interventions to maintain or to improve their health status, or (c) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. The term "medically fragile child" shall also include traumatic brain injury, the nature of which typically requires care in a specialty care center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions of this subdivision. Notwithstanding the definitions set forth in this subdivision, any patient which has received prior approval from a health maintenance organization for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child

at least until discharge from that facility occurs.

§ 4402. Health maintenance organizations; application for certificate of authority. 1. No person or groups of persons may operate a health maintenance organization or issue a contract to an enrollee for membership in a comprehensive health services plan without first obtaining a certificate of authority from the commissioner.

2. In order to receive such a certificate of authority, a person or persons, hereinafter designated as the applicant, intending to operate a health maintenance organization shall file an application for such certificate on such form as the commissioner shall prescribe, and shall provide to the satisfaction of the commissioner the following:

(a) a copy of each of the basic organizational documents and agreements of the applicant and all participating entities, including all contracts and agreements relating to the provision of comprehensive health services;

(b) a copy of the bylaws, rules and regulations on internal governing documents of the applicant;

(c) a list of the names, addresses and official positions of the persons comprising the applicant and all entities referred to in paragraph (a) other than those possessing a valid operating certificate under the provisions of article twenty-eight of this chapter, including all owners of record or beneficial, all members of the governing body, the officers and directors in the case of a corporation, and the partners or members in the case of a partnership or corporation, and the agent for service of process;

(d) a statement of the financial condition of the organization, including, if appropriate, an income statement, balance sheet and projected sources and uses of funds;

(e) a statement generally describing the proposed operation of the health maintenance organization as to the location of its facilities, the type and quantity of health care personnel engaged to provide services, its quality assurance mechanism, its grievance procedure, participating hospitals and such other data as may be required by the commissioner;

(f) a copy of each enrollee contract filed with and approved by the superintendent pursuant to section forty-four hundred six of this article; and

(g) such other information as may be required by the commissioner to make the determinations required in section forty-four hundred three of this article.

§ 4403. Health maintenance organizations; issuance of certificate of authority. 1. The commissioner shall not issue a certificate of authority to an applicant therefor unless the applicant demonstrates that:

(a) it has defined a proposed enrolled population to which the health maintenance organization proposes to provide comprehensive health services and has established a mechanism by which that population may advise in determining the policies of the organization;

(b) it has the capability of organizing, marketing, managing, promoting and operating a comprehensive health services plan;

(c) it is financially responsible and may be expected to meet its obligations to its enrolled members. For the purpose of this paragraph, "financially responsible" means that the applicant shall assume full financial risk on a prospective basis for the provision of comprehensive health services, including hospital care and emergency medical services within the area served by the plan, except that it may require providers to share financial risk under the terms of their contract, it may have financial incentive arrangements with providers or it may obtain insurance or make other arrangements for the cost of providing comprehensive health services to enrollees; any insurance or other arrangement required by this paragraph shall be approved as to adequacy by the superintendent as a prerequisite to the issuance of any certificate of authority by the commissioner;

(d) the character, competence, and standing in the community of the proposed incorporators, directors, sponsors or stockholders, are satisfactory to the commissioner;

(e) the prepayment mechanism of its comprehensive health services plan, the bases upon which providers of health care are compensated, and the anticipated use of allied health personnel are conducive to the use

of ambulatory care and the efficient use of hospital services;

(f) acceptable procedures have been established to monitor the quality of care provided by the plan, which, in the case of services provided by non-participating providers, shall be limited to the provision of reports to the primary care practitioner responsible for supervising and coordinating the care of the enrollee;

(g) approved mechanisms exist to resolve complaints and grievances initiated by any enrolled member; and

(h) the contract between the enrollee and the organization meet the requirements of the superintendent as set forth in section forty-four hundred six of this article, as to the provisions contained therein for health services, the procedures for offering, renewing, converting and terminating contracts to enrollees, and the rates for such contracts including but not limited to, compliance with the provisions of section one thousand one hundred nine of the insurance law.

2. The commissioner may adopt and amend rules and regulations pursuant to the state administrative procedure act to effectuate the purposes and provisions of this article. Such regulations may include rules and procedures addressing the provision of emergency services, including patient notification, obtaining authorization for treatment, transfer of patients from one facility to another and emergency transportation arrangements.

3. Nothing contained in this section shall preclude any person or persons in developing a health maintenance organization from contacting potential participants to discuss the health care services such organization would offer, prior to the granting of a certificate of authority.

4. Nothing in this article shall preclude any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or which would authorize enrollees to receive assistance from federal funds.

5. (a) The commissioner, at the time of initial licensure, at least

every three years thereafter, and upon application for expansion of service area, shall ensure that the health maintenance organization maintains a network of health care providers adequate to meet the comprehensive health needs of its enrollees and to provide an appropriate choice of providers sufficient to provide the services covered under its enrollee's contracts by determining that (i) there are a sufficient number of geographically accessible participating providers; (ii) there are opportunities to select from at least three primary care providers pursuant to travel and distance time standards, providing that such standards account for the conditions of accessing providers in rural areas; (iii) there are sufficient providers in each area of specialty practice to meet the needs of the enrollment population; (iv) there is no exclusion of any appropriately licensed type of provider as a class; and (v) contracts entered into with health care providers neither transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of this section, nor penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(b) The following criteria shall be considered by the commissioner at the time of a review: (i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; (iii) the availability of appropriate and timely care that is in compliance with the standards of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance and regulations issued under those Acts, which shall include an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services; (iv) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for

appointments, appropriateness of referrals and other indicators of plan capacity; and regulations to be promulgated by the commissioner. The commissioner shall determine standards for network adequacy for mental health and substance use disorder treatment services, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services and mobile crisis intervention services and propose regulations, in consultation with the superintendent of financial services, the commissioner of the office of mental health and the commissioner of the office of addiction services and supports by December thirty-first, two thousand twenty-three.

(c) Each organization shall report on an annual basis the number of enrollees and the number of participating providers in each organization.

6. (a) If a health maintenance organization determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the health maintenance organization shall make a referral to an appropriate provider, pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the non-participating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(b) A health maintenance organization shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the health maintenance organization, or the primary care provider in consultation with the medical director of the organization and specialist if any, determines that such a standing referral is appropriate, the organization shall make such a referral to a specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized

and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(c) A health maintenance organization shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the health maintenance organization, or primary care provider in consultation with a medical director of the organization and a specialist, if any, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the organization shall refer the enrollee to such specialist. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialist, except pursuant to the provisions of paragraph (a) of this subdivision. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee. Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If an organization refers an enrollee to a non-participating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

(d) A health maintenance organization shall have a procedure by which an enrollee with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition.

If the health maintenance organization, or the primary care provider or the specialist designated pursuant to paragraph (c) of this subdivision, in consultation with a medical director of the organization, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the organization shall refer the enrollee to such center. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialty care center, unless the organization does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health maintenance organization, in consultation with the primary care provider, if any, or a specialist designated pursuant to paragraph c of this subdivision, and the enrollee or the enrollee's designee. If an organization refers an enrollee to a specialty care center that does not participate in the organization's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network. For purposes of this paragraph, a specialty care center shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph a of subdivision two of section forty-four hundred six-d of this chapter, the health maintenance organization shall provide written notice to the enrollee of the provider's disaffiliation and permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of: (i) ninety days from the later of the date of the notice to the enrollee of the provider's disaffiliation from the organization's network or the effective date of the provider's disaffiliation from the organization's network; or (ii) if the enrollee is pregnant at the time of the provider's disaffiliation, the duration of the pregnancy and post-partum

care directly related to the delivery.

(2) During the transitional period the health care provider shall: (i) continue to accept reimbursement from the health maintenance organization at the rates applicable prior to the start of the transitional period, and continue to accept the in-network cost-sharing from the enrollee, if any, as payment in full; (ii) adhere to the organization's quality assurance requirements and to provide to the organization necessary medical information related to such care; and (iii) otherwise adhere to the organization's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization.

* (f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance organization, the organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to sixty days from the effective date of enrollment, if (i) the enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition or (ii) the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to otherwise adhere to the organization's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization. In no event shall this paragraph be construed to require a

health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

* NB Effective until January 1, 2027

* (f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance organization, the organization shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to ninety days from the effective date of enrollment. If the enrollee is pregnant at the effective date of enrollment, the transitional period shall include the provision of care for the duration of the pregnancy and postpartum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees: (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to otherwise adhere to the organization's policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization. In no event shall this paragraph be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

* NB Effective January 1, 2027

7. A health maintenance organization that requires or provides for designation by an enrollee of a participating primary care provider shall permit the enrollee to designate any participating primary care provider who is available to accept such individual, and in the case of a child, shall permit the enrollee to designate a physician (allopathic

or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the health maintenance organization.

* 8. Notwithstanding any provision of law to the contrary, a health maintenance organization may expand its comprehensive health services plan to include services operated, certified, funded, authorized or approved by the office for people with developmental disabilities, including habilitation services as defined in paragraph (c) of subdivision one of section forty-four hundred three-g of this article, and may offer such expanded plan to a population of persons with developmental disabilities, as such term is defined in the mental hygiene law, subject to the following:

(a) Such organization must have the ability to provide or coordinate services for persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities. Such criteria shall include, but not be limited to, adequate experience providing or coordinating services for persons with developmental disabilities;

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such organization lacks the experience required in paragraph (a) of this subdivision, the organization shall have an affiliation arrangement with an entity or entities that are non-profit organizations or organizations whose shareholders are solely controlled by non-profit organizations with experience serving persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria including, but not limited to, residential, day, and employment services such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

(a-2) Each enrollee shall receive services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided

that all such services are consistent with such person's wishes to the extent that such wishes are known and the individual's needs. With respect to an individual receiving non-residential services operated, certified, funded, authorized or approved by the office for people with developmental disabilities prior to enrollment in the organization, such guidelines shall require the organization to contract with the current provider of such non-residential services at the rates established by the office for ninety days, in order to ensure continuity of care. With respect to an individual living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the organization, the organization shall contract with the provider of residential services for that residence at the rates established by the office for people with developmental disabilities for so long as such person lives in that residence pursuant to an approved plan of care;

(b) The provision by such organization of services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to the joint oversight and review of both the department and the office for people with developmental disabilities. The department and such office shall require such organization to provide comprehensive care planning, assess quality, meet quality assurance requirements and ensure the enrollee is involved in care planning.

(c) Such organization shall not provide or arrange for services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until the commissioner and the commissioner of the office for people with developmental disabilities approve program features and rates that include such services, and determine that such organization meets the requirements of this paragraph and any other requirements set forth by the commissioner of the office for people with developmental disabilities;

(d) An otherwise eligible enrollee receiving services through the organization that are operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall not be involuntarily disenrolled from such organization without the prior approval of the commissioner of the office for people with developmental disabilities. Notice shall be provided to the enrollee and

the enrollee may request a fair hearing regarding such disenrollment;

(e) The office for people with developmental disabilities shall determine the eligibility of individuals receiving services operated, certified, funded, authorized or approved by such office to enroll in such a plan and shall enroll individuals it determines eligible in an organization chosen by such individual, guardian or other legal representative;

(f) The office for people with developmental disabilities, or its designee, shall complete a comprehensive assessment for enrollees that receive services operated, certified, funded, authorized or approved by such office. This assessment shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee as such needs relate to such enrollee's health, safety, living environment and wishes, to the extent such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person-centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The initial assessment shall be completed by such office or its designee other than the organization and shall be completed, in consultation with the prospective enrollee's health care practitioner as necessary. Reassessments shall be completed by the office or its designee, which may be the organization. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made.

(f-1) Such organization shall provide the department and the office for people with developmental disabilities with a description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice.

(g) No person with a developmental disability shall be required to enroll in a comprehensive health services plan as a condition of receiving medical assistance and services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until program features and reimbursement rates are approved

by the commissioner and the commissioner of the office for people with developmental disabilities and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons with developmental disabilities pursuant to this article operating in the person's county of residence to meet the needs of persons with developmental disabilities, and that such plans meet the standards of this section.

(h) Organizations providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to all requirements applicable to DISCOs operating under section forty-four hundred three-g of this article with respect to quality assurance, grievances and appeals, informed choice, participating in development of plans of care and requirements with respect to marketing, to the extent that such requirements are not inconsistent with this section.

(i) The provisions of this subdivision shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided hereunder to recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, as may be necessary to ensure such federal financial participation. To the extent that the provisions of this subdivision are inconsistent with other provisions of this article or with the provisions of section three hundred sixty-four-j of the social services law, the provisions of this subdivision shall prevail.

* NB Repealed December 31, 2027

9. A health maintenance organization shall have procedures for coverage of medically fragile children including those necessary to implement section forty-four hundred six-i of this article.

*** § 4403-a. Special purpose certificate of authority.** 1. The commissioner may issue a special purpose certificate of authority to a

provider, applying on forms prescribed by the commissioner, seeking to offer a comprehensive health services plan on a prepaid contractual basis either directly, or through an arrangement, agreement or plan or combination thereof to an enrolled population, which is substantially composed of persons eligible to receive benefits under title XIX of the federal social security act or other public programs.

2. A not-for-profit corporation established to operate a hospital pursuant to article twenty-eight of this chapter, a government agency, an entity or a group of entities seeking to provide comprehensive health services pursuant to the provisions of this section may apply for a special purpose certificate of authority; provided, however, that a shared health facility, as defined by article forty-seven of the public health law, shall not be eligible for such a certificate.

3. The commissioner shall not issue a special purpose certificate of authority unless the applicant has demonstrated to the commissioner's satisfaction that the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met, provided, however, that the commissioner may waive one or more of such requirements, or portions thereof, pertaining to financial risk, employer requirements and subscriber contracts if he determines that such waiver will serve to promote the efficient provision of comprehensive health services and that the proposed plan will provide an appropriate and cost-effective alternative method for the delivery of such services in a manner which will meet the needs of the population to be served.

4. (a) No contract for the provision of comprehensive health services pursuant to this section shall be entered into by a local social services district unless the commissioner certifies that all pertinent requirements with respect to financial arrangements, rates, and standards relating to arrangements for and the delivery of patient care services have been satisfied and that the contract and related arrangements will ensure access to and the delivery of high quality, appropriate medical services including an assurance that recipients' access to preventive health services is not diminished.

(b) No contract for the provision of comprehensive health services to persons eligible for medical assistance under title eleven of article five of the social services law shall be entered into without the approval of the commissioner of social services pursuant to section three hundred sixty-five-a of the social services law and the state director of the budget. The commissioner of social services shall not approve such a contract unless the contract:

(i) provides that enrollment shall be voluntary and contains provisions to ensure that persons eligible for medical assistance will be provided sufficient information regarding the plan to make an informed and voluntary choice whether to enroll or, in the event that enrollment in the entity is pursuant to section three hundred sixty-four-j of the social services law, provides that enrollment in the entity is governed by that section;

(ii) provides adequate safeguards to protect persons eligible for medical assistance from being misled concerning the plan and from being coerced into enrolling in the plan or, in the event that enrollment in the entity is undertaken pursuant to section three hundred sixty-four-j of the social services law, provides that enrollment in the entity is governed by that section;

(iii) establishes adequate opportunities for public review and comment prior to implementation of the plan;

(iv) provides adequate grievance procedures for recipients who enroll in the plan; and

(v) establishes quality assurance mechanisms.

5. A special purpose certificate of authority shall be issued to an approved provider of comprehensive health services for a maximum effective period of twenty-four months subject to the applicable provisions of section forty-four hundred four of this article and provided that federal financial participation is available for expenditures made on behalf of recipients of medical assistance. The commissioner upon application, after consultation with the commissioner of social services, may issue a certificate for an additional period of up to twenty-four months if satisfied that the plan has and will continue to demonstrate satisfactory performance and compliance with all requirements imposed for initial certification. If the plan provides

comprehensive services pursuant to a contract solely to individuals eligible for medical assistance under title eleven of article five of the social services law, the certificate shall expire when (a) the medical assistance contract is revoked or expires and is not extended or renewed or (b) federal approval of the medical assistance contract is withdrawn.

6. All individuals eligible for medical assistance enrolling voluntarily in a comprehensive health services plan offered by an entity with a special purpose certificate of authority will be given thirty days from the effective date of enrollment in the plan to disenroll without cause. After this thirty day disenrollment period, all individuals participating in the plan will be enrolled for a period of six months, except that all participants will be permitted to disenroll for good cause, as defined by the commissioner of social services in regulation.

7. Notwithstanding any inconsistent provision of this section, the commissioner shall issue special purpose certificates of authority pursuant to this section to no more than eighteen entities other than those entities initially authorized by chapter seven hundred fifteen of the laws of nineteen hundred eighty-two and by a chapter of the laws of nineteen hundred eighty-four authorizing the Monroe county medicap demonstration project.

* NB Expires March 31, 2029

*** § 4403-b. Development of comprehensive health services plans.** The commissioner is authorized, after consultation with the commissioner of social services, and subject to the approval of the director of the budget, to make grants to diagnostic and treatment centers and general hospitals operating pursuant to article twenty-eight of this chapter, to aid in the planning, development and implementation of comprehensive health services plans. The total amount expended pursuant to this section shall not exceed the amount appropriated for such purposes in any fiscal year.

* NB Expires March 31, 2029

*** § 4403-c. Comprehensive HIV special needs plan certification.** 1. No person or group of persons may operate a comprehensive HIV special needs plan without first obtaining a certificate of authority from the commissioner. Any person may apply for a comprehensive HIV special needs certificate of authority, provided, however, that a shared health facility, as defined in article forty-seven of this chapter, shall not be eligible for such a certificate.

2. An applicant for certification shall submit the following information and documentation to the satisfaction of the commissioner:

(a) a copy of the applicant's basic organizational documents and agreements of the applicant and all network members, including all contracts and agreements relating to the provision of HIV services;

(b) a copy of any current licensure or certification maintained by the applicant;

(c) a description of any experience the applicant may have had in providing HIV services which are licensed, certified, funded or approved by the department, including identification of any disciplinary, administrative or criminal proceedings related to such services in the past ten years, the resolution thereof, and any other proceedings currently pending;

(d) full disclosure of the financial condition of the applicant and of members of the board, officers, controlling persons, owners and partners, including, but not limited to, a statement of the applicant's assets, resources, accounts receivable, liabilities and proposed sources and uses of funds and the most recent certified income statement and balance sheet;

(e) a demonstration of the applicant's ability to provide or continue to provide quality HIV services;

(f) a description of the geographic area served and to be served by the applicant;

(g) a description of the applicant's current capacity, and proposed capacity, to provide or arrange for the provision of comprehensive HIV services for a defined geographic area to a defined population; and

(h) such other information as the commissioner shall require.

3. The commissioner shall not issue a comprehensive HIV special needs plan certificate of authority to an applicant therefor unless the applicant demonstrates that:

(a) it has defined an enrolled population to which the comprehensive HIV special needs plan proposes to provide comprehensive HIV health services, has demonstrated a willingness to enroll any person who is eligible for enrollment within its defined catchment area and has established a mechanism by which the enrolled population may participate in determining the policies of the organization;

(b) it has defined a specific network of providers and facilities that are capable of providing comprehensive HIV special needs services to the enrolled population described in paragraph (a) of this subdivision;

(c) it has the capability of organizing, marketing, managing, promoting and operating a comprehensive HIV special needs plan;

(d) it is financially responsible and sound and may be expected to meet its obligations to its enrolled members. For the purposes of this paragraph, "financially responsible" means that the applicant is capable of assuming full financial risk on a prospective basis for the provision of comprehensive HIV special needs services within the geographic catchment area defined by the applicant except that it may allow providers to share financial risk under the terms of their contract, or it may obtain insurance or make other arrangements for the cost of providing comprehensive HIV special needs health services to enrollees; any insurance or other arrangements proposed to meet this requirement shall be approved as to adequacy as a prerequisite to the issuance of any comprehensive HIV special needs certificate of authority by the commissioner. In making a determination of financial soundness, the commissioner shall consider financial information, contracts and agreements required as part of the application for a certificate of authority and any other information that the commissioner shall deem necessary to make that determination. For purposes of this section, any grants awarded to an applicant contingent upon its approval as a HIV special needs plan certified pursuant to this section, shall be considered when making a determination of fiscal soundness;

(e) it has established a system which appropriately accounts for costs and a uniform system of reports and audits meeting the requirements of

the commissioner;

(f) the character, competence and standing in the community of the proposed incorporators, directors, sponsors, or stockholders of the plan, and its network providers, are satisfactory to the commissioner;

(g) it is willing and able to assure that necessary HIV services will be provided in a timely manner to assure the availability and accessibility of adequate personnel and facilities; to assure continuity of care for enrollees; and to implement procedures for referrals, as requested, to appropriate care for affected family members of the enrolled population;

(h) the prepayment mechanism of its comprehensive HIV special needs plan, the bases upon which the providers of health care are compensated, and the anticipated use of allied health personnel are conducive to the use of ambulatory care and the efficient use of hospital services;

(i) acceptable procedures have been established for the conduct of outreach and enrollment of persons with HIV infection including persons who are homeless, substance users and other vulnerable populations;

(j) acceptable procedures have been developed to communicate with participants in a linguistically and culturally competent manner;

(k) acceptable procedures have been established to monitor the quality of care provided by the plan and to assure that all care rendered meets clinical standards of HIV care as established and maintained by the AIDS Institute of the New York state department of health;

(l) approved mechanisms exist to resolve complaints and grievances initiated by any enrolled member; and

(m) the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met.

4. The commissioner shall not issue a comprehensive HIV special needs certificate of authority unless the applicant has demonstrated to the commissioner's satisfaction that the requirements of this article and any regulations promulgated pursuant thereto have been met and will continue to be met, provided, however, that the commissioner may impose alternative requirements, or portions thereof, particularly those related to capitalization, if he or she determines that such alternative requirements will serve to promote the high quality, efficient provision of comprehensive health services or services required by HIV positive

persons, will promote the development of HIV special needs plans and that the proposed plan will provide an appropriate and cost-effective alternative method for the delivery of such services in a manner which will meet the needs of the population to be served.

5. The commissioner shall make a determination on an application after receipt of all required and requested information and documentation.

6. The commissioner shall review and approve any current or proposed contracts or agreements with current or prospective network members, and provided further, that the commissioner shall specifically review and approve any proposed provisions in such contracts or agreements with the prospective or existing network members which specify any risk sharing arrangements.

7. The commissioner may revoke, limit or annul a comprehensive HIV special needs plan certificate of authority in accordance with the provisions of section forty-four hundred four of this article.

8. A comprehensive HIV special needs plan, certified pursuant to this section, shall be responsible for providing or arranging for all medical assistance services defined under section three hundred sixty-five-a of the social services law, including delivery of a comprehensive benefit package, which shall include early and periodic screening; adolescent health; diagnosis and treatment and child/teen health screenings; referrals for necessary services; linkages to HIV counseling and testing; and HIV prevention and education activities. A comprehensive HIV special needs plan provider shall be responsible for assisting enrollees in the prudent selection of such services including but not limited to:

(a) referral, coordination, monitoring and follow-up with regard to other medical services providers, as appropriate for diagnosis and treatment, or direct provision of all medical assistance services;

(b) methods of assuring enrollees' access to specialty services outside the comprehensive HIV special needs plan's network or panel when the plan does not have a provider with the appropriate training and experience in its network to meet the particular health care needs of

the participant;

(c) the establishment of appropriate utilization and referral requirements for physicians, hospitals, and other medical services providers, including emergency room visits and inpatient admissions;

(d) the creation of mechanisms to ensure the participation of HIV centers of excellence and community-based HIV care providers;

(e) implementation of procedures for managing the care of all participants, including the use of facility and community-based case managers with expertise in the care needs of persons with HIV infection, and the designation of a specialist as a primary care practitioner;

(f) development of appropriate methods of managing the HIV care needs of homeless, substance users and other vulnerable populations, who are enrolled in the comprehensive HIV special needs plan, to assure that all necessary services are made available in a timely manner, in accordance with prevailing standards of professional medical practice, and that all appropriate referrals and follow-up treatments are provided;

(g) provision of all early periodic screening, diagnosis and treatment services, as well as periodic screening and referral, to each participant under the age of twenty-one, at regular intervals and as medically appropriate;

(h) direct provision of or arrangement for the provision of comprehensive prenatal care services to all pregnant participants in accordance with standards adopted by the department of health and with statute and regulations governing HIV testing of pregnant women and newborns;

(i) implementation of procedures for written agreements, which may include contractual agreements, with community-based social service providers to ensure access to the full continuum of services needed by HIV infected persons; and

(j) permit the use of standing referrals to specialists and subspecialists for participants who require the care of such practitioners on a regular basis.

9. Notwithstanding any other provision of law, a comprehensive HIV special needs plan certified pursuant to this section shall limit enrollment to HIV positive persons, except for the following persons who may be enrolled regardless of their HIV status:

(a) related children up to the age of twenty-one; and

(b) individuals who are homeless or who are members of other high need populations which, in the discretion of the commissioner, would benefit from receiving services through a plan certified pursuant to this section; provided however, that rates paid to special needs plans for such populations shall be comparable to rates paid for the same populations in other managed care plans.

10. Enrollment and disenrollment. (a) Enrollment in a comprehensive HIV special needs plan shall be voluntary and persons eligible for enrollment in such plans shall be afforded the opportunity to choose among such plans, to the extent available in the locality where the person currently resides; provided however that enrollment may be automatic after federal approval of a waiver or waivers or other federal action required to institute automatic enrollment, pursuant to applicable provisions of the federal social security act, and that persons automatically enrolled in a comprehensive HIV special needs plan shall have the opportunity to withdraw from such plan in accordance with paragraph (g) of subdivision four, paragraph (b) of subdivision three and subdivision twelve of section three hundred sixty-four-j of the social services law. The department shall ensure to the maximum extent practicable that individuals are provided with a choice of comprehensive HIV special needs plans.

(b) The commissioner shall promulgate regulations establishing criteria which relate to enrollment and disenrollment of enrollees in comprehensive HIV special needs plans. Comprehensive HIV special needs plans shall not request disenrollment of an enrollee based on any diagnosis, condition, or perceived diagnosis or condition, or an enrollee's efforts to exercise his or her rights under a grievance process.

(c) Prior to enrollment in a comprehensive HIV special needs plan individuals are to be provided with a full written explanation of all fee-for-service and other options and given a reasonable opportunity to choose between the comprehensive HIV special needs plan and the other options. In addition, enrollees shall be provided notice of their right to disenroll from the plan, except as otherwise provided in this subdivision.

(d) If an enrollee requests to change a provider or disenroll from a comprehensive HIV special needs plan pursuant to this subdivision, the social services district and the plan shall implement such change in a timely manner in accordance with standards established by the commissioner. When an enrollee changes comprehensive HIV special needs plan providers the plan must effectuate the timely transfer of all necessary medical records.

(e) Plans shall ensure that any new enrollee whose health care provider is not a member of the plan's provider network, who enrolls in the plan, can continue with an ongoing course of treatment with the enrollee's current health care provider during a transitional period of up to sixty days from the effective date of enrollment. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the comprehensive HIV special needs plan for the transitional period only if the health care provider agrees: (1) to accept reimbursement from the comprehensive HIV special needs plan at rates established by the plan as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the plan's network for such services; (2) to adhere to the plan's quality assurance requirements and agrees to provide to the plan any necessary medical information related to such care; and (3) to otherwise adhere to the plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the comprehensive HIV special needs plan. In no event shall this paragraph be construed to require a comprehensive HIV special needs plan to provide coverage for benefits not otherwise covered;

(f) Comprehensive HIV special needs plans shall ensure that for those enrollees whose health care provider leaves the comprehensive HIV special needs plan's network of providers, the enrollee shall be permitted to continue an ongoing course of treatment with such current health care provider during a transitional period of up to ninety days from the date of notice to the enrollee of the provider's disaffiliation from the plan's network. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the comprehensive HIV special needs plan for the transitional period only if the health care provider agrees: (1) to

accept reimbursement from the comprehensive HIV special needs plan at rates established by the plan as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the plan's network for such services; (2) to adhere to the organization's quality assurance requirements and agrees to provide to the plan any necessary medical information related to such care; and (3) to otherwise adhere to the plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the comprehensive HIV special needs plan. In no event shall this paragraph be construed to require a comprehensive HIV special needs plan to provide coverage for benefits not otherwise covered;

11. The commissioner shall develop and certify capitated payment rates for comprehensive HIV special needs plans, subject to the approval of the director of the division of the budget. In developing capitation rates the commissioner shall be authorized to consider, at a minimum, the age, eligibility category, historic cost and utilization of covered enrollees and covered services, anticipated costs of emerging HIV treatment modalities and the expected impact of delivering services in a managed care environment.

12. Plans certified under this section must submit financial reports in a manner and frequency established by the commissioner.

13. The department shall establish a stop-loss reinsurance program for comprehensive HIV special needs plans. The stop-loss reinsurance program shall be designed in a manner which promotes the development and ongoing financial viability of the comprehensive HIV special needs plan by providing reasonable protection for catastrophic cases and adverse selection.

14. Quality assurance. (a) The department shall be responsible for establishing a comprehensive quality assurance program for comprehensive HIV special needs plans. This quality assurance program shall reflect clinical standards of HIV care established and maintained by the AIDS Institute in the department. The department shall monitor the

performance, quality and utilization of such plans on at least an annual basis. Such plans must describe and document the existence of a formal, organized quality assurance program with the capacity to identify, address and follow-up on issues which concern the care and services delivered to enrollees. Such reviews are to include, but not be limited to, the following:

(1) compliance with performance and outcome-based quality standards promulgated by the department;

(2) appropriateness, accessibility, timeliness, and quality of care delivered by such providers;

(3) referrals, coordination, monitoring and follow-up with regard to other medical service providers;

(4) methods of ensuring enrollees access to specialty services outside the plan's network or panel when the plan does not have a provider with the appropriate training and experience in the network or panel to meet the particular HIV care needs of the participant;

(5) delivery of a comprehensive benefit package, including early and periodic screening; adolescent health; diagnosis and treatment and child/teen health screenings; referrals for necessary services, and linkages to HIV counseling and testing; HIV prevention and education activities;

(6) mechanisms for the provision of all information to enrollees in clear and coherent terms that are commonly used in a culturally and linguistically appropriate and understandable manner;

(7) existence of a management information system to support quality assurance activities, which system shall provide for the collection and utilization of data including but not limited to enrollment, complaints, encounters and specific performance indicators; and

(b) the commissioner shall have access to patient specific medical information and enrollee medical records, including encounter data, maintained by a comprehensive HIV special needs plan for the purposes of quality assurance and oversight.

(c) The department shall be responsible for establishing and maintaining a uniform system of reports relating to the quality of care and services furnished by comprehensive HIV special needs plans.

15. The commissioner may revoke, limit or annul a comprehensive HIV

special needs certificate of authority in accordance with the provisions of section forty-four hundred four of this article.

16. Confidentiality. Except as provided in paragraph (c) of subdivision fourteen of this section, any enrollee information maintained by a comprehensive HIV special needs plan shall be kept confidential in accordance with section forty-four hundred eight-a of this article and where applicable section 33.13 of the mental hygiene law and any other applicable state or federal law.

17. Utilization review. A comprehensive HIV special needs plan authorized under this section is required to meet requirements set forth in article forty-nine of this chapter.

18. Disclosure. Each enrollee and prospective enrollee prior to enrollment in a comprehensive HIV special needs plan shall be provided with written disclosure information related to enrollee benefits, rights and obligations pursuant to section forty-four hundred eight of this article.

19. Grievance procedure. Comprehensive HIV special needs plans authorized under this section shall be required to meet grievance procedures requirements pursuant to section forty-four hundred eight-a of this article.

20. Prohibitions. A comprehensive HIV special needs plan authorized under this section shall be required to meet the requirements set forth in section forty-four hundred six-c of this article.

21. The commissioner is authorized, subject to the approval of the director of the division of the budget, and within amounts appropriated, to make grants to those entities seeking certification to operate a comprehensive HIV special needs plan to aid in the development of the systems, organizational structures and networks necessary to operate a managed care program. The commissioner is authorized to develop criteria for distribution of the grants. The grants may also be used to meet the capitalization standards and the reserve and escrow deposit requirements

established for comprehensive HIV special needs plans.

22. Comprehensive HIV special needs plans shall function distinctly from other comprehensive or non-comprehensive health plans operated by the same organization, corporation, persons, county or municipality and shall be clearly distinguished from any other functions through the maintenance of separate records, reports and accounts for the comprehensive HIV special needs plan function.

23. The commissioner shall establish reserve and escrow deposit requirements for HIV special needs plans.

24. Nothing in this section shall be construed to require that a health maintenance organization, certified pursuant to the provisions of this article, apply for a comprehensive HIV special needs plan certificate of authority pursuant to this section; provided, however, that a health maintenance organization, certified pursuant to the provisions of this article, which proposes to operate a comprehensive HIV special needs plan shall be required to comply with all the provisions of this section.

* NB Repealed March 31, 2030

§ 4403-d. Special needs managed care plans. No person, group of persons, county or counties may operate a special needs managed care plan without first obtaining a certificate of authority from the commissioner, issued jointly with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services.

*** § 4403-e. Primary care partial capitation providers; partial capitation certificate of authority.** 1. The commissioner may issue partial capitation certificates of authority to qualified individual medical services providers, counties or entities comprised of medical services providers, applying on forms prescribed by the commissioner, seeking to offer medical assistance services, including primary and

preventive care and case management of inpatient, emergency room, specialty, and pharmacy services, to recipients of medical assistance eligible to enroll in managed care plans, on a partial capitation basis. Partial capitation certificates of authority shall only be awarded to qualified applicants in rural areas of the state where comprehensive health services plans, as defined in section forty-four hundred one of this article, are not yet available, provided that such certificate shall be awarded only until full capitation becomes practicable. Comprehensive primary and preventive care shall include all services and related ancillary procedures routinely performed in a primary care physicians office, including preventive care and immunizations in accordance with CTH periodic schedules and routine obstetrical-gynecological services. Notwithstanding, where partial capitation providers currently exist, they will be allowed to continue operation. Provided, however, that a shared health facility, as defined in article forty-seven of this chapter, shall not be eligible for such a certificate.

2. Applications for a partial capitation certificate of authority shall include the following:

- (a) current licensure or certification;
- (b) a description of the applicant's experience in providing the services included as part of comprehensive primary and preventive care, including identification of any disciplinary, administrative or criminal proceedings related to such license, certification or services and the resolution thereof;
- (c) a description of the applicant's financial resources, together with a copy of the applicant's latest certified financial statement and the medical malpractice insurance coverage maintained by such applicant;
- (d) an assessment of the applicant's ability to continue to provide high quality services in exchange for payments and to assume the financial risk of operating on a partial capitation basis;
- (e) the geographic area to be served by the applicant;
- (f) the applicant's current capacity, and proposed capacity to provide or directly arrange for the provision of medical care and services to persons eligible for medical assistance;
- (g) a statement of intent to contract from the local social services

district in which they will operate;

(h) a statement describing procedures to be used to monitor the quality of care provided by the plan;

(i) such other information as the commissioner shall require; and

(j) in the case of an application from a local social services district, such comparable information as the commissioner may require.

3. The commissioner may issue a partial capitation certificate of authority to an applicant that meets the following criteria:

(a) the applicant can demonstrate its ability to control, arrange for and manage in-patient hospital and emergency room care through written agreements with participating hospitals;

(b) the applicant is board-certified or board-eligible in his or her area of specialty, or has completed an accredited residency program, or has admitting privileges at one or more hospitals, or in the case of an entity, all medical services providers affiliated with the applicant are board-certified or board-eligible in his or her area of specialty, has completed an accredited residency program, or has admitting privileges at one or more hospitals;

(c) the applicant directly provides or arranges for the delivery of comprehensive primary and preventive care and services and access to medical advice and emergency care on a twenty-four hour basis;

(d) the applicant has adequate medical malpractice liability insurance coverage;

(e) the applicant has demonstrated it is financially responsible and may be expected to meet its obligations to its enrolled members. For purposes of this paragraph, "financially responsible" means that the applicant shall assume financial risk on a prospective basis for the provision of comprehensive primary care and preventive services, and can support the necessary administrative costs associated with the activities of a partial capitation plan, for its enrolled members;

(f) the applicant has demonstrated the ability to provide high quality care, and to monitor the quality of care provided via an acceptable formal quality assurance program;

(g) the local social services district has provided written evidence of its intention to contract with the plan; and

(h) the applicant has demonstrated the ability to track and monitor

all services provided to its enrollees, and its ability to submit periodic cost and utilization reports, as the commissioner may require.

* NB Repealed March 31, 2030

*** § 4403-f. Managed long term care plans.** 1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

(b) "Eligible applicant" means an entity controlled or wholly owned by one or more of the following: a hospital as defined in subdivision one of section twenty-eight hundred one of this chapter; a home care agency licensed or certified pursuant to article thirty-six of this chapter; an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of this article (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six), or a health maintenance organization authorized under article forty-three of the insurance law; or a not-for-profit organization which has a history of providing or coordinating health care services and long term care services to the elderly and disabled.

(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care, acute care and behavioral health services if so authorized.

2. Certificate of authority; form. An eligible applicant shall submit an application for a certificate of authority to operate a managed long term care plan upon forms prescribed by the commissioner. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

(a) a description of the service area proposed to be served by the plan with projections of enrollment that will result in a fiscally sound plan;

(b) a description of the proposed target population and the marketing plan;

(c) adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section.

3. Certificate of authority; approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

(a) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

(b) that it will include an enrollment process which shall ensure that enrollment in the plan is informed. The application shall describe the disenrollment process, which shall provide that an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

(c) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

(d) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

(e) readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit

coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(f) readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed pursuant to title XIX of the federal social security act;

(g) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

(h) that the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care. In addition, such guidelines shall require managed long term care plans to offer and cover consumer directed personal assistance services for eligible individuals who elect such services pursuant to section three hundred sixty-five-f of the social services law; and

(i) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

4. Solvency. (a) The commissioner shall be responsible for evaluating, approving and regulating all matters relating to fiscal solvency, including reserves, surplus and provider contracts. The commissioner may promulgate regulations to implement this section. The commissioner, in the administration of this subdivision:

(i) shall be guided by the standards which govern the fiscal solvency of a health maintenance organization, provided, however, that the commissioner shall recognize the specific delivery components, operational capacity and financial capability of the eligible applicant for a certificate of authority;

(ii) shall not apply financial solvency standards that exceed those required for a health maintenance organization; and

(iii) shall establish reasonable capitalization and contingent reserve requirements.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of enrollees in managed long term care plans. The commissioner shall be satisfied that the eligible applicant is financially sound, and has made adequate provisions to pay for services.

4-a. Role of the superintendent of financial services. (a) The superintendent of financial services shall determine and approve premiums in accordance with the insurance law whenever any population of enrollees not eligible under title XIX of the federal social security act is to be covered. The determination and approval of the superintendent of financial services shall relate to premiums charged to such enrollees not eligible under title XIX of the federal social security act.

(b) The superintendent of financial services shall evaluate and approve any enrollee contracts whenever such enrollee contracts are to cover any population of enrollees not eligible under title XIX of the federal social security act.

5. Applicability of other laws. A managed long term care plan shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

6. Approval authority. (a) An applicant shall be issued a certificate

of authority as a managed long term care plan upon a determination by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section. The commissioner shall issue no more than seventy-five certificates of authority to managed long term care plans pursuant to this section.

(a-1) Nothing in this section shall be construed as requiring the department to contract with or to contract for a particular line of business with an entity certified under this section for the provision of services available under title eleven of article five of the social services law. A managed long term care plan that has been issued a certificate of authority, or an applicant for a certificate of authority as a managed long term care plan that has in any of the three calendar years immediately preceding the application, met any of the following criteria shall not be eligible for a contract for the provision of services available under title eleven of article five of the social services law: (i) classified as a poor performer, or substantially similar terminology, by the centers for medicare and medicaid services; or (ii) an excessive volume of penalties, statements of findings, statements of deficiency, intermediate sanctions or enforcement actions, regardless of whether the applicant has addressed such issues in a timely manner.

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) For the period beginning April first, two thousand twelve and ending March thirty-first, two thousand fifteen, the majority leader of the senate and the speaker of the assembly may each recommend to the commissioner, in writing, up to four eligible applicants to convert to be approved managed long term care plans. An applicant shall only be approved and issued a certificate of authority if the commissioner determines that the applicant meets the requirements of subdivision three of this section. The majority leader of the senate or the speaker of the assembly may assign their authority to recommend one or more

applicants under this section to the commissioner.

(d) (i) Effective April first, two thousand twenty, and expiring March thirty-first, two thousand twenty-seven, the commissioner shall place a moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan pursuant to this section, including applications seeking authorization to expand an existing managed long term care plan's approved service area or scope of eligible enrollee populations. Such moratorium shall not apply to:

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

(B) applications seeking approval to transfer ownership or control of an existing managed long term care plan;

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

(D) applications seeking to operate under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or to serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan, based on the need for such plans and the experience of applicants in serving dually eligible individuals as determined by the commissioner in their discretion.

(ii) For the duration of the moratorium, the commissioner shall assess the public need for managed long term care plans that are not integrated with an affiliated Medicare plan, the ability of such plans to provide high quality and cost effective care for their membership, and based on such assessment develop a process and conduct an orderly wind-down and elimination of such plans, which shall coincide with the expiration of the moratorium unless the commissioner determines that a longer wind-down period is needed.

(e) For the duration of the moratorium under paragraph (d) of this subdivision, the commissioner shall establish, and enforce by means of a

premium withholding equal to three percent of the base rate, an annual cap on total enrollment (enrollment cap) for each managed long term care plan, subject to subparagraphs (ii) and (iii) of this paragraph, based on a percentage of each plan's reported enrollment as of October first, two thousand twenty.

(i) The specific percentage of each plan's enrollment cap shall be established by the commissioner based on: (A) the ability of individuals eligible for such plans to access health and long term care services, (B) plan quality of care scores, (C) historical plan disenrollment, (D) the projected growth of individuals eligible for such plans in different regions of the state, (E) historical plan enrollment of patients with varying levels of need and acuity, and (F) other factors in the commissioner's discretion to ensure compliance with federal requirements, appropriate access to plan services, and choice by eligible individuals.

(ii) In the event that a plan exceeds its annual enrollment cap, the commissioner is authorized under this paragraph to retain all or a portion of the premium withheld based on the amount over which a plan exceeds its enrollment cap. Penalties assessed pursuant to this subdivision shall be determined by regulation.

(iii) The commissioner may not establish an annual cap on total enrollment under this paragraph for plans' lines of business operating under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or that serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan.

(f) In implementing the provisions of paragraphs (d) and (e) of this subdivision, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.

6-a. Performance standards. (a) On or before January first, two thousand twenty-four, each managed long term care plan that has been issued a certificate of authority pursuant to this section shall have an active Medicare Dual Eligible Special Needs Plan in operation whose H-contract either has a current quality star rating from the Centers for Medicare and Medicaid Services of three stars or higher, or has not been issued a quality star rating from the Centers for Medicare and Medicaid Services. In addition, the managed long term care plan shall sufficiently demonstrate success in the following performance categories:

(i) in addition to meeting the requirements of paragraph (j) of subdivision seven of this section, in order to ensure network adequacy a commitment to contracting with an adequate number of licensed home care service agencies needed to provide necessary personal care services to the greatest practicable number of enrollees, and with an adequate number of fiscal intermediaries needed to provide necessary consumer directed personal assistance services to the greatest practicable number of enrollees in accordance with section three hundred sixty-five-f of the social services law;

(ii) readiness to timely implement and adhere to maximum wait time criteria for key categories of service in accordance with laws, rules and regulations of the department or the Centers for Medicare and Medicaid Services;

(iii) commitment to quality improvement;

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

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

(vi) ability to serve enrollees across the continuum of care, as demonstrated by the type and number of products the managed long term care operates or has applied to operate, including integrated care for participants who are dually eligible for Medicaid and Medicare, and those operated under title one-A of article twenty-five of this chapter and section three hundred sixty-nine-gg of the social services law; and

(vii) value based care readiness and experience.

(b) The commissioner shall require any managed long term care plan

with a Medicare Dual Eligible Special Needs Plan in operation that at any time has a current quality star rating from the Centers for Medicare and Medicaid Services of less than three stars to establish and implement a performance improvement plan acceptable to the commissioner, and which shall be consistent with the standards of the Medicare Advantage Quality Rating System.

(c) The commissioner shall have the authority to promulgate regulations to effectuate the provisions of this subdivision.

(d) The provisions of this subdivision shall not apply for managed long term care plans operating under a certificate of authority pursuant to subdivision twelve, as added by section seventy-six of part A of chapter fifty-six of the laws of two thousand thirteen, or subdivision thirteen of this section, or to the program of all-inclusive care for the elderly under article twenty-nine-EE of this chapter.

7. Program oversight and administration. (a)(i) The commissioner shall promulgate regulations to implement this section and to ensure the quality, appropriateness and cost-effectiveness of the services provided by managed long term care plans. The commissioner may waive rules and regulations of the department, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver will promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of enrollees will not be impaired as a result of such waiver. In order to achieve managed long term care plan system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioner may establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet component quality requirements, and require a uniform cost report. The commissioner shall require managed long term care plans to utilize quality improvement measures, based on health outcomes data, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of

the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation, and subject to the provisions of subdivision eight of section three hundred sixty-five-a of the social services law.

* (b) (i) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for a continuous period of more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means

committee and the senate and assembly health committees simultaneously with their submission to the federal government.

(ii) The commissioner, shall seek input from representatives of home and community-based long term care services providers, recipients, and the Medicaid managed care advisory review panel, among others, to further evaluate and promote the transition of persons in receipt of home and community-based long term care services into managed long term care plans and other care coordination models and to develop guidelines for such care coordination models. The guidelines shall be finalized and posted on the department's website no later than November fifteen, two thousand eleven.

(iii) Notwithstanding and in addition to any provision of subparagraph (i) of this paragraph and subject to any federal requirements, persons dually eligible for medical assistance and benefits under the federal Medicare program who are enrolled in a Medicare Dual Eligible Special Needs Plan and who do not require community-based long term care services, as specified by the commissioner, for a continuous period of more than one hundred and twenty days shall be required to enroll with an available affiliated plan certified pursuant to this section when program features and reimbursement rates are approved by the commissioner.

(v) The following medical assistance recipients shall not be eligible to participate in a managed long term care program or other care coordination model established pursuant to this paragraph until program features and reimbursement rates are approved by the commissioner and, as applicable, the commissioner of developmental disabilities:

(1) a person enrolled in a managed care plan pursuant to section three hundred sixty-four-j of the social services law;

(2) a participant in the traumatic brain injury waiver program or a person whose circumstances would qualify him or her for the program as it existed on January first, two thousand fifteen;

(3) a participant in the nursing home transition and diversion waiver program or a person whose circumstances would qualify him or her for the program as it existed on January first, two thousand fifteen;

(4) a person enrolled in the assisted living program;

(5) a person enrolled in home and community based waiver programs administered by the office for people with developmental disabilities;

(6) a person who is expected to be eligible for medical assistance for less than six months, for a reason other than that the person is eligible for medical assistance only through the application of excess income toward the cost of medical care and services;

(7) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;

(8) a person receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;

(9) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the social services district;

(10) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of the social services law;

(11) a person who is eligible for medical assistance pursuant to paragraph (b) of subdivision four of section three hundred sixty-six of the social services law;

(12) Native Americans;

(13) a person who is permanently placed in a nursing home for a consecutive period of three months or more. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees; and

(14) a person who has not been assessed as needing at least limited assistance with physical maneuvering with more than two activities of daily living, or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one activity of daily living, as defined and determined using an evidenced based validated assessment instrument approved by the commissioner and in accordance with applicable state and federal law and regulations of the department, provided that the provisions of this clause shall not apply to a person who has been continuously enrolled in a managed long term care program beginning prior to October first, two thousand twenty.

(v-a) For purposes of clause two of subparagraph (v) of this paragraph, program features shall be substantially comparable to those services available to traumatic brain injury waiver participants as of January first, two thousand fifteen, subject to federal financial participation.

(v-b) For purposes of clause three of subparagraph (v) of this paragraph, program features shall be substantially comparable to those services offered to nursing home transition and diversion waiver participants as of January first, two thousand fifteen, subject to federal financial participation.

(v-c) Any managed care program providing services under clause two or three of subparagraph (v) of this paragraph shall have an adequate network of trained providers to meet the needs of enrollees and provide services under this subdivision.

(v-d) Any individual providing service coordination pursuant to subparagraph (v-a) or (v-b) of this paragraph shall exercise his or her professional duties in the interests of the patient. Nothing in this subparagraph shall be construed as diminishing the authority and obligations of a managed long term care plan under this article and article forty-nine of this chapter.

(vi) persons required to enroll in the managed long term care program or other care coordination model established pursuant to this paragraph shall have no less than thirty days to select a managed long term care provider, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider, the commissioner shall assign such participant to a managed long term care provider, taking into account consistency with any prior community-based direct care workers having recently served the recipient, quality performance criteria, capacity and geographic accessibility. During the period prior to receiving services from a managed long term care provider assigned under this subparagraph, the person may receive services under fee for service Medicaid.

(vii) If another long term care plan certified under this section is available, medical assistance recipients required to enroll in such plans pursuant to this section, including recipients who have been assigned to a provider by the commissioner, may change plans without cause within ninety days of either notification of enrollment or the

effective date of enrollment into a plan, whichever is later, by submitting a request to the entity designated by the department in a format to be determined by the department. In accordance with federal statutes and regulations, after such ninety-day period, the department may prohibit a recipient from changing plans more frequently than once every twelve months, except for good cause. Good cause may include poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with the enrollee's care needs, or as otherwise determined by the commissioner.

(viii) Managed long term care provided and plans certified or other care coordination model established pursuant to this paragraph shall comply with the provisions of paragraphs (d), (i), (t), and (u) and subparagraph (iii) of paragraph (a) and subparagraph (iv) of paragraph (e) of subdivision four of section three hundred sixty-four-j of the social services law.

(ix) (1) The commissioner shall report biannually on the implementation of this subdivision. The reports shall include, but not be limited to:

(A) satisfaction of enrollees with care coordination/case management; timeliness of care;

(B) service utilization data including changes in the level, hours, frequency, and types of services and providers;

(C) enrollment data, including auto-assignment rates by plan;

(D) quality data; and

(E) continuity of care for participants as they move to managed long term care, with respect to community based and nursing home populations, including pediatric nursing home populations, and medically fragile children being served by home care agencies affiliated with pediatric nursing homes and diagnostic and treatment centers primarily serving medically fragile children.

(2) The commissioner shall publish the report on the department's website and provide notice to the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on health, the chair of the assembly health committee and the Medicaid Managed Care Advisory Review Panel upon availability of the report. The initial report shall be provided by September first, two thousand twelve. The reports shall be made available by each February first, and

September first thereafter. Such reports shall be formatted to allow comparisons between plans.

* NB Effective until April 1, 2027

* (b) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. Copies of such original waiver applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

* NB Effective April 1, 2027

(c)(i) A managed long term care plan shall not use deceptive or coercive marketing methods to encourage participants to enroll. A managed long term care plan shall not distribute marketing materials to potential enrollees before such materials have been approved by the commissioner.

(ii) The commissioner shall ensure, through periodic reviews of managed long term care plans, that enrollment was an informed choice; such plan has only enrolled persons whom it is authorized to enroll, and plan services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioner in regulations.

(d) Notwithstanding any provision of law, rule or regulation to the contrary, the commissioner may issue a request for proposals to carry out reviews of enrollment and assessment activities in managed long term care plans and operating demonstrations with respect to enrollees eligible to receive services under title XIX of the federal social security act to determine if enrollment meets the requirements of subparagraph (ii) of paragraph (c) of this subdivision; and that assessments of such enrollees' health, functional and other status, for the purpose of adjusting premiums, were accurate.

(e) The commissioner may, in his or her discretion for the purpose of protection of enrollees, impose measures including, but not limited to,

bans on further enrollments and requirements for use of enrollment brokers until any identified problems are resolved to the satisfaction of the commissioner.

(f) Continuation of a certificate of authority issued under this section shall be contingent upon satisfactory performance by the managed long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf of enrollees who are eligible to receive services under title XIX of the federal social security act.

(g) * (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social, cognitive, and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee, including appropriate community-based referrals. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

* NB Effective until April 1, 2027

* (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the prospective enrollee, including appropriate community-based referrals.

* NB Effective April 1, 2027

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner as necessary. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least annually by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

(h) * The commissioner and, in the case of a plan arranging for or providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities, the commissioner of the office for people with developmental disabilities, shall, upon request by a managed long term care plan or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

* NB Effective until December 31, 2027

* The commissioner shall, upon request by a managed long term care plan or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

* NB Effective December 31, 2027

(i) information concerning utilization of services and providers by each of its enrollees prior to and during enrollment, including but not limited to utilization of emergency department services, prescription

drugs, and hospital and nursing facility admissions.

(ii) aggregate data concerning utilization and costs for enrollees and for comparable cohorts served through the Medicaid fee-for-service program.

(j) Limitations on licensed home care service agency contracts. (i) The commissioner may establish methodologies to limit the number of licensed home care services agencies licensed pursuant to article thirty-six of the public health law with which managed long term care plans may enter into contracts, provided that such limitations are consistent with the specifications set forth in this paragraph.

(ii) Managed long term care plans operating in the city of New York and/or the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region in a maximum number calculated based upon the following methodology:

(A) As of October first, two thousand eighteen, one contract per seventy-five members enrolled in the plan within such region; and

(B) As of October first, two thousand nineteen, one contract per one hundred members enrolled in the plan within such region.

(iii) Managed long term care plans operating in counties other than those in the city of New York and the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region in a maximum number calculated based upon the following methodology:

(A) As of October first, two thousand eighteen, one contract per forty-five members enrolled in the plan within such region.

(B) As of October first, two thousand nineteen, one contract per sixty members enrolled in the plan within such region.

(iv) Notwithstanding subparagraphs (ii) and (iii) of this paragraph, a managed long term care plan shall not enter into less than the number of contracts with licensed home care services agencies in each county in which the plan operates as is necessary to remain consistent with network adequacy standards, as determined by the department in accordance with federal regulations.

(v) When calculating the number of additional contracts that a managed long term care plan may enter using the methodologies established pursuant to this paragraph, any fractional result shall be rounded down.

(vi) The commissioner may increase the number of licensed home care

services agencies with which a managed long term care plan may contract, on a county by county basis, if the commissioner determines that such increase is necessary to: ensure adequate access to services in the geographic area including, but not limited to, special needs services and services that are culturally and linguistically appropriate; or to avoid disruption in services in the geographic area.

(vii) Any licensed home care services agency that ceases operation as a result of this paragraph shall conform with all applicable requirements, including but not limited to demonstrating to the department's satisfaction continuity of care for individuals receiving services from the agency.

(viii) The commissioner may require managed long term care plans to provide evidence of compliance with this paragraph, on an annual basis.

(ix) In implementing the provisions of this paragraph, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.

(x) This subparagraph applies where implementation of the limits on contracts with licensed home care service agencies of this paragraph (i) would otherwise require an enrollee's care to be transferred from the enrollee's current licensed home care service agency to another licensed care service agency, and (ii) the enrollee (or the enrollee's authorized representative) wants the enrollee to continue to be cared for by one or more employees of the current licensed home care service agency, and that continuation would otherwise be provided. In such a case: the enrollee's managed long term care plan may contract with the enrollee's current licensed home care service agency for the purpose of continuing the enrollee's care by such employee or employees, and the contract shall not count towards the limits on contracts under this paragraph for a period of three months.

(k) Increased rates, terms or scope of payment for behavioral health services under this section, where payment is made by an entity under this section, as a result of a rate, coverage or other change made

pursuant to a law, regulation, rule or official guidance, shall be deemed in effect on the same date that such change would have taken effect if payment were made other than by the entity. Where payment is not made as of the effective date, the entity shall make retroactive payments to the appropriate service providers.

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care shall comply with all applicable laws and regulations, state and federal, including regulations as to actuarial soundness for medicaid managed care.

8-a. Rates for certain residential health care facilities. Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to article twenty-eight of this chapter located in a county with a population of more than seventy-two thousand and less than seventy-five thousand persons based on the two thousand ten federal census shall be reimbursed by any managed long term care plan, approved pursuant to this section and contracting with the department, at a rate of no less than one hundred four percent of the average rate of reimbursement in

existence on March first, two thousand eighteen for such county.

9. Reports. The department shall provide an interim report to the governor, temporary president of the senate and the speaker of the assembly on or before April first, two thousand three and a final report on or before April first, two thousand six on the results of the managed long term care plans under this section. Such results shall be based on data provided by the managed long term care plans and shall include but not be limited to the quality, accessibility and appropriateness of services; consumer satisfaction; the mean and distribution of impairment measures of the enrollees by payor for each plan; the current method of calculating premiums and the cost of comparable health and long term care services provided on a fee-for-service basis for enrollees eligible for services under title XIX of the federal social security act; and the results of periodic reviews of enrollment levels and practices. Such reports shall provide data on the demographic and clinical characteristics of enrollees, voluntary and involuntary disenrollments from plans, and utilization of services and shall examine the feasibility of increasing the number of plans that may be approved. Data collected pursuant to this section shall be available to the public in an aggregated format to protect individual confidentiality, however under no circumstance will data be released on items with cells with smaller than statistically acceptable standards.

10. Notwithstanding any inconsistent provision to the contrary, the enrollment and disenrollment process and services provided or arranged by all operating demonstrations or any program that receives designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, must meet all applicable federal requirements. Services may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm

systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services.

11. The department shall develop transition and continuity of care policies for participants in home and community based long term care, including the long term home health care program, as they move to managed long term care plans addressing:

(a) a timetable and plan for implementation and transition by participants, plans and providers;

(b) informative disclosure of participants' options as to impending actions affecting or relating to the home care services they receive;

(c) reasonable opportunity for plans' and providers' good faith pursuit of contracts, program changes or state approvals relevant to plan implementation;

(d) notice that a participant with a previously established plan of care provided by a certified home health agency or long term home health care program, or provided pursuant to the personal care or consumer directed personal assistance service programs, may elect to have such care plan continued subject to the participant's next comprehensive assessment; and

(e) delineation of responsibilities for service delivery and care coordination, so as to avoid conflict, duplication and unnecessary disruption of direct care staffing for the patient, and maintain compliance with state and federal statute and regulation, including the provisions of this section, article thirty-six of this chapter and section three hundred sixty-five-f of the social services law.

In addition, the department shall provide technical assistance to long term home health care providers with contracting options under this section. The department shall work with affected stakeholders in the development of these policies.

11-a. In transitioning individuals to managed long term care, the department shall provide oversight of long term managed care by ensuring:

(a) participants are appropriately notified of the upcoming changes to their health care, and their rights and options;

(b) access to appropriate enrollment assistance, consumer assistance and complaint mechanisms;

(c) access to quality care by requiring network transparency and choice of long term care plans, allowing patients to choose the plan that best fits their needs;

(d) transparency and accountability from providers, which shall include a mechanism by which staff, participants and family members can confidentially report concerns relating to quality to the plan and the state;

(e) plans and providers are assessed periodically and data is published regarding enrollment in integrated care designs, network adequacy, new service designs, outcome measures, including the extent to which care plans are continued or altered based upon new comprehensive assessments, and the types and amounts of services health plans have authorized;

(f) mechanisms are in place to state oversight of enrollment and services to prevent waste and abuse in the managed long term care system; and

(g) incentives are provided for a variety of indicators, including but not limited to, smooth patient transitions, appropriate enrollment, quality care, high staff retention and positive health care outcomes achieved at a low cost.

11-b. In cases of a managed long term care plan merger, acquisition, or other similar arrangement approved by the department, any receiving plan that is a party to the arrangement shall submit a report to the department within twelve months of the effective date of the transaction. Such reports shall be in a form and format to be determined by the department and shall include, but not be limited to, information about the enrollees transferred and enrollee service authorization data before and after transfer. The department shall make a summary of the report available to the public.

** 12. The commissioner may make any necessary amendments to a contract pursuant to this section with a managed long term care plan, as defined in paragraph (a) of subdivision one of this section, to allow

such managed long term care plan to participate as a qualified health plan in a state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

** NB There are 2 sb 12's

** 12. Notwithstanding any provision to the contrary, a managed long term care plan may expand the services it provides or arranges for to include services operated, certified, funded, authorized or approved by the office for people with developmental disabilities for a population of persons with developmental disabilities, as such term is defined in the mental hygiene law, including habilitation services as defined in paragraph (c) of subdivision one of section forty-four hundred three-g of this article, subject to the following:

(a) Such plan must have the ability to provide or coordinate services for persons with developmental disabilities as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities. Such criteria shall include, but not be limited to, adequate experience providing or coordinating services for persons with developmental disabilities;

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such plan lacks the experience required in paragraph (a) of this subdivision, the plan shall have an affiliation arrangement with an entity or entities that are non-profit organizations or organizations whose shareholders are solely controlled by non-profit organizations with experience serving persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria including, but not limited to, residential, day and employment services, such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

(a-2) Each enrollee shall receive services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable

that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known. With respect to an individual receiving non-residential services operated, certified, funded, authorized or approved by the office for people with developmental disabilities prior to enrollment in the plan, such guidelines shall require the plan to contract with the current provider of such non-residential services at the rates established by the office for ninety days in order to ensure continuity of care. With respect to an individual living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the plan, the plan shall contract with the provider of residential services for that residence at the rates established by the office for people with developmental disabilities for so long as such individual lives in that residence pursuant to an approved plan of care;

(b) The provision by such plan of services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject the joint oversight and review of both the department and the office for people with developmental disabilities. The department and such office shall require such organization to provide comprehensive care planning, assess quality, meet quality assurance requirements and ensure the enrollee is involved in care planning;

(c) Such plan shall not provide or arrange for services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until the commissioner and the commissioner of the office for people with developmental disabilities approve program features and rates that include such services, and determine that such organization meets the requirements of this subdivision and any other requirements set forth by the commissioner of the office for people with developmental disabilities;

(d) An otherwise eligible enrollee receiving services through the plan that are operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall not be involuntarily disenrolled from such plan without the prior approval of the commissioner of the office for people with developmental

disabilities. Notice shall be provided to the enrollee and the enrollee may request a fair hearing regarding such disenrollment;

(e) The office for people with developmental disabilities shall determine the eligibility of individuals receiving services operated, certified, funded, authorized or approved by such office to enroll in such plan and shall enroll individuals it determines eligible in a plan chosen by such individual, guardian or other legal representative;

(f) The office for people with developmental disabilities, or its designee, shall complete a comprehensive assessment for enrollees who receive services operated, certified, funded, authorized or approved by such office. This assessment shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee as such needs relate to each individual's health, safety, living environment and wishes, to the extent that such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person-centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The initial assessment shall be completed by such office or a designee other than the plan and shall be completed in consultation with the prospective enrollee's health care practitioner as necessary. Reassessments shall be completed by such office or its designee, which may be the managed long term care plan in which the person is enrolled or proposes to enroll. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made.

(f-1) The plan shall provide the department and the office for people with developmental disabilities with a description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice.

(g) Plans providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to all requirements applicable to DISCOs operating under section forty-four hundred three-g of this article with respect to

quality assurance, grievances and appeals, informed choice, participation in development of plans of care and requirements with respect to marketing, to the extent that such requirements are not inconsistent with this section.

(h) No person with a developmental disability shall be required to enroll in a managed long term care plan as a condition of receiving medical assistance and services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until program features and reimbursement rates are approved by the commissioner and the commissioner of the office for people with developmental disabilities and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons with developmental disabilities pursuant to this article operating in the person's county of residence to meet the needs of persons with developmental disabilities, and that such plans meet the standards of this section.

** NB Repealed December 31, 2027

** NB There are 2 sb 12's

** 13. Notwithstanding any inconsistent provision to the contrary, the commissioner may issue a certificate of authority to no more than three eligible applicants who are eligible for Medicare and medical assistance to operate managed long term care plans that are authorized to exclusively enroll persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. The commissioner may only issue certificates of authority pursuant to this subdivision if, and to the extent that, the department has received federal approval to operate a fully integrated duals advantage program for the integration of services for persons enrolled in Medicare and medical assistance. The commissioner may waive any of the department's regulations as the commissioner, in consultation with the commissioner of the office for people with developmental disabilities, deems necessary to allow such managed long term care plans to provide or arrange for services for persons with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety.

** NB Repealed December 31, 2027

** 14. The provisions of subdivisions twelve and thirteen of this

section shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided thereunder to recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, as may be necessary to ensure such federal financial participation. To the extent that the provisions of subdivision twelve and thirteen of this section are inconsistent with other provisions of this article or with the provisions of section three hundred sixty-four-j of the social services law, the provisions of this subdivision shall prevail.

** NB Repealed December 31, 2027

* NB Repealed December 31, 2029

*** § 4403-g. Developmental disability individual support and care coordination organizations.** 1. Definitions. As used in this section:

(a) "Developmental disability individual support and care coordination organization" or "DISCO" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, as determined by the commissioner and the commissioner of the office for people with developmental disabilities, on a capitated basis in accordance with this section, for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law, which the organization is authorized to enroll.

(b) "Eligible applicant" means an entity controlled by one or more non-profit organizations which have a history of providing or coordinating health and long term care services to persons with developmental disabilities.

(c) "Habilitation services" means services available through the state's home and community based services waiver for persons with developmental disabilities, state plan for medical assistance, and any other authorized federal funding for such services designed to assist persons in acquiring, retaining, and improving the self-help,

socialization, and adaptive skills necessary to reside successfully in home and community based settings.

(d) "Health and long term care services" means comprehensive health services and other services as determined by the commissioner and the commissioner of the office for people with developmental disabilities, whether provided by state-operated programs or not-for-profit entities, including, but not limited to, habilitation services, home and community-based and institution-based long term care services, and ancillary services, that shall include medical supplies and nutritional supplements, that are necessary to meet the needs of persons whom the plan is authorized to enroll. Each person enrolled in a DISCO shall receive health and long term care services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known and in accordance with such person's needs.

2. Approval authority. An applicant shall be issued a certificate of authority as a DISCO for purposes of participating in the people first waiver program pursuant to section 13.40 of the mental hygiene law upon a determination by the commissioner and the commissioner of the office for people with developmental disabilities that the applicant complies with the operating requirements for a DISCO under this section.

3. Application for certificate of authority; form. The commissioner and the commissioner of the office for people with developmental disabilities shall jointly develop application forms for a certificate of authority to operate a DISCO. An eligible applicant shall submit an application for a certificate of authority to operate a DISCO upon forms prescribed by such commissioners. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

(a) A description of the service area proposed to be served by the DISCO with projections of enrollment that will result in a fiscally

sound plan;

(b) A description of the services to be covered by such DISCO, which must include all health and long term care services, as defined in paragraph (d) of subdivision one of this section, and other services as determined by the commissioner and the commissioner of the office for people with developmental disabilities;

(c) A description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice;

(d) The names of the providers proposed to be in the DISCO's network;

(e) Evidence of the character and competence of the applicant's proposed operators, and of the incorporators, directors, stockholders or members of the applicant;

(f) Adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including affiliate agreements or proposed contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section;

(g) A description of the proposed quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and care coordination services to ensure continuity, quality, appropriateness and coordination of care;

(h) A description of the proposed quality assessment and performance improvement program that includes performance and outcome based quality standards for enrollee health status and satisfaction, and data collection and reporting for standard performance measures;

(i) A description of the management systems and systems to process payment for covered services;

(j) A description of how achievement of person-centered outcomes, as defined by the commissioner of the office for people with developmental disabilities, shall be assessed, as well as a description of how health and long term care services shall be used to meet such outcomes;

(k) A description of the mechanism to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound

clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(l) A description of the systems for securing and integrating any potential sources of funding for services provided by or through the organization, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act and all other available sources of funding;

(m) A description of the proposed contractual arrangements for providers of health and long term care services in the benefit package; and

(n) Information related to the financial condition of the applicant.

4. Certificate of authority approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the satisfaction of the commissioner and the commissioner of the office for people with developmental disabilities:

(a) That it will have in place acceptable quality assurance mechanisms, grievance procedures and mechanisms to protect the rights of enrollees and care coordination services to ensure continuity, quality, appropriateness and coordination of care;

(b) That it will have in place a mechanism or means to assure that persons with developmental disabilities can make informed choices either individually or through an authorized decision maker regarding the development of a person-centered plan, as defined by the commissioner of the office for people with developmental disabilities;

(c) That it has developed a quality assessment and performance improvement program that includes performance and outcome based quality standards for enrollee health status and satisfaction, which shall be reviewed by the commissioner and the commissioner of the office for people with developmental disabilities. The program shall include data collection and reporting for standard performance measures as required by the commissioner and the commissioner of the office for people with developmental disabilities;

(d) That an otherwise eligible enrollee shall not be involuntarily disenrolled without the prior approval of the commissioner of the office for people with developmental disabilities;

(e) That the applicant shall not use deceptive or coercive marketing methods to encourage participants to enroll and that the applicant shall not distribute marketing materials to potential enrollees before such materials have been approved by the commissioner and the commissioner of the office for people with developmental disabilities;

(f) Satisfactory evidence of the character and competence of the applicant's proposed operators, incorporators, directors, stockholders and members;

(g) Reasonable assurance that the applicant will provide high quality services to an enrolled population, that the applicant's network of providers is adequate and that such providers have demonstrated sufficient competency to deliver high quality services to the enrolled population and that policies and procedures will be in place to address the cultural and linguistic needs of the enrolled population;

(h) Sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

(i) Readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(j) Readiness and capability of organizing, marketing, managing, promoting and operating a health and long term care services plan, or has an affiliation agreement with an entity that has such readiness and capability;

(k) Willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by or through the DISCO, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act and all other available sources of funding;

(l) That the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner

and the commissioner of the office for people with developmental disabilities. With respect to a person receiving non-residential services operated, certified, funded, authorized or approved by the office for people with developmental disabilities prior to enrollment in the DISCO, such guidelines shall require the DISCO to contract with the current provider of non-residential services at the rates established by the office for ninety days, in order to ensure continuity of care. With respect to a person living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the DISCO, such guidelines shall require the DISCO to contract with the provider of residential services for that residence at the rates established by the office for so long as such individual lives in that residence pursuant to an approved plan of care;

(m) That the applicant is financially responsible and shall be expected to meet its obligations to its enrolled members; and

(n) That the applicant shall assess person-centered outcomes as defined by the commissioner of the office for people with developmental disabilities, and has satisfactory mechanisms by which it will assess how health and long term care services will be used to meet such outcomes.

5. Enrollment. (a) Only persons with developmental disabilities, as determined by the office for people with developmental disabilities, shall be eligible to enroll in DISCOs.

(b) The office for people with developmental disabilities or its designee shall enroll an eligible person in the DISCO chosen by him or her, his or her guardian or other legal representative, provided that such DISCO is authorized to enroll such person.

(c) No person with a developmental disability who is receiving or applying for medical assistance and who is receiving, or eligible to receive, services funded, certified, authorized or approved by the office for people with developmental disabilities, shall be required to enroll in a DISCO in order to receive such services until program features and reimbursement rates are approved by the commissioner and the commissioner of the office for people with developmental disabilities, and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons

with developmental disabilities pursuant to this article operating in such person's county of residence to meet the needs of persons with developmental disabilities, and that such DISCOs meet the standards of this section. No person shall be required to enroll in a DISCO in order to receive services operated, funded, certified, authorized or approved by the office for people with developmental disabilities until there are at least two plans authorized to coordinate care for persons with developmental disabilities pursuant to this article in such person's county of residence, unless federal approval is secured to require enrollment when there are less than two such entities operating in such county.

(d) Persons required to enroll in a DISCO shall have no less than sixty days to select a DISCO, and such persons and their guardians or other legal representatives shall be provided with information to make an informed choice. Where a person, guardian or other legal representative has not selected a DISCO, the commissioner of the office for people with developmental disabilities or its designee shall enroll such person in a DISCO chosen by such commissioner, taking into account quality, capacity and geographic accessibility. The office for people with developmental disabilities or its designee shall automatically re-enroll a person with the same DISCO if there is a loss of medicaid eligibility of two months or less.

(e) Enrolled persons may change their enrollment at any time without cause, provided, however, that a person required to enroll in a DISCO in order to receive services funded, licensed, authorized or approved by the office for people with developmental disabilities may only disenroll from a DISCO if he or she enrolls in another DISCO authorized to enroll him or her. Such disenrollment shall be effective no later than the first day of the second month following the request.

(f) A DISCO may request the involuntary disenrollment of an enrolled person in writing to the office for people with developmental disabilities. Such disenrollment shall not be effective until the request is reviewed and approved by such office. Notice shall be provided to the enrollee and the enrollee may request a fair hearing regarding such disenrollment. The department and the office for people with developmental disabilities shall adopt rules and regulations governing this process.

6. Assessments. The office for people with developmental disabilities, or its designee, shall complete a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee in a DISCO as such needs relate to each individual's health, safety, living environment and wishes, to the extent that such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person-centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The assessment shall be completed by the office for people with developmental disabilities or in consultation with the prospective enrollee's health care practitioner as necessary. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made. The office for people with developmental disabilities may designate the DISCO to perform reassessments, but shall not designate the DISCO to perform the initial assessment of a prospective enrollee.

7. Program oversight and administration. (a) The commissioner and the commissioner of the office for people with developmental disabilities shall jointly promulgate regulations to implement this section, to provide for oversight of DISCOs, including on site reviews, and to ensure the quality, appropriateness and cost-effectiveness of the services provided by DISCOs.

(b) The commissioner and the commissioner of the office for people with developmental disabilities may waive rules and regulations of their respective department or office, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver shall promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of DISCO enrollees shall not be impaired as a result of such waiver. The commissioners shall report annually to the legislature and to the joint advisory council established pursuant to section 13.40 of the mental hygiene law on all

rules and regulations waived pursuant to this paragraph. In order to achieve DISCO system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioners shall establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet component quality requirements, and require a uniform cost report. The commissioners shall require DISCOs to utilize quality improvement measures, based on the achievement of personal outcomes and quality of life, health outcomes data, and assessments of individual and family satisfaction, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(c) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner in consultation with the commissioner of the office for people with developmental disabilities shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act are inconsistent with the flexibility necessary for the efficient administration of DISCOs, and such regulations shall provide that such provisions shall not be applicable to enrollees of DISCOs, provided that such determinations are consistent with applicable federal law and regulation.

(d) The commissioner and the commissioner of the office for people with developmental disabilities shall ensure, through periodic reviews of DISCOs, that organization services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioners in regulations.

(e) The commissioner and the commissioner of the office for people with developmental disabilities shall have the authority to conduct both on site and off site reviews of DISCOs. Such reviews may include, but not be limited to, the following components: governance; fiscal and financial reporting; recordkeeping; internal controls; marketing; network contracting and adequacy; program integrity assurances; utilization control and review systems; grievance and appeals systems; quality assessment and assurance systems; care management; enrollment

and disenrollment; management information systems, and other operational and management components.

8. Solvency. (a) The commissioner, in consultation with the commissioner of the office for people with developmental disabilities, shall be responsible for evaluating, approving and regulating all matters relating to fiscal solvency, including reserves, surplus and provider contracts. The commissioner shall promulgate regulations to implement this section. The commissioner, in the administration of this subdivision:

(i) shall be guided by the standards that govern the fiscal solvency of a health maintenance organization, provided, however, that the commissioner shall recognize the specific delivery components, operational capacity and financial capability of the eligible applicant for a certificate of authority;

(ii) shall not apply financial solvency standards that exceed those required for a health maintenance organization; and

(iii) shall establish reasonable capitalization and contingent reserve requirements.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of enrollees in the DISCO. The commissioner shall be satisfied that the eligible applicant is financially sound, and has made adequate provisions to pay for quality services that are cost effective and appropriate to needs and the protection of health, safety, welfare and satisfaction of those served.

9. Role of the superintendent of financial services. (a) The superintendent of financial services shall determine and approve premiums in accordance with the insurance law whenever any population of enrollees not eligible under title XIX of the federal social security act is to be covered. The determination and approval of the superintendent of financial services shall relate to premiums charged to such enrollees not eligible under title XIX of the federal social security act.

(b) The superintendent of financial services shall evaluate and approve any enrollee contracts whenever such enrollee contracts are to cover any population of enrollees not eligible under title XIX of the

federal social security act.

10. Payment rates for DISCO enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget. Payment rates shall be actuarially sound for covered services, including but not limited to habilitation services, and, when there is sufficient reliable data to permit, shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, which may include: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner and the commissioner of the office for people with developmental disabilities. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories.

11. Continuation of certificate of authority. Continuation of a certificate of authority issued under this section shall be contingent upon compliance by the DISCO with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the DISCO; and federal financial participation in payments on behalf of enrollees who are eligible to receive services under title XIX of the federal social security act.

12. Protection of enrollees. The commissioner may, in his or her discretion and with the concurrence of the commissioner of the office for people with developmental disabilities, for the purpose of the protection of enrollees, impose measures including, but not limited to bans on further enrollments until any identified problems are resolved to the satisfaction of the commissioner, or fines upon a finding that the DISCO has failed to comply with the provisions of any applicable statute, rule or regulation.

13. Information sharing. The commissioner and the commissioner of the office for people with developmental disabilities shall, as necessary

and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such DISCO the following data if it is available:

(a) information concerning utilization of services and providers by each of its enrollees prior to and during enrollment.

(b) Aggregate data concerning utilization and costs for enrollees and for comparable cohorts served through the Medicaid fee-for-service program.

14. Applicability of other laws. DISCOs shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated thereunder. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

15. Effectiveness. The provisions of this section shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided by the DISCOs to enrollees who are recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, in order to ensure such federal financial participation.

* NB Repealed December 31, 2027

§ 4404. Health maintenance organizations; continuance of certificate of authority. 1. Continuance by the commissioner of a certificate of authority issued under section forty-four hundred three of this article shall be contingent upon satisfactory performance by the organization as to the delivery, continuity, accessibility and quality of the services to which an enrolled member is entitled, compliance with the provisions of this article and rules and regulations promulgated thereunder, and the continuing fiscal solvency of the organization as set out in this

section.

2. Except as provided in subdivision three of this section, the commissioner may revoke, limit or annul a certificate of authority as of the termination of the current period of all then existing enrollee contracts, after a hearing, and only after a finding of unsatisfactory performance or fiscal insolvency. However, in the event of such revocation, limitation or annulment, the organization shall be prohibited from entering into any new enrollee contracts as of the date of notification of such action by the commissioner. Notification of such action shall be given by the organization to each enrollee. The commissioner shall give prior notice of such action to the superintendent.

3. The commissioner may revoke or limit a certificate of authority, after a hearing, for violations of any applicable statute or rules and regulations which threatened to directly affect the health, safety or welfare of any enrollee. Upon notice of his intent to revoke or limit a certificate of authority, the commissioner may prohibit the organization from entering into any new enrollee contracts pending final action and may require notification of such action to be given by the organization to each enrollee. The commissioner shall give prior notice to the superintendent of his intent to prohibit the organization from entering into any enrollee contracts. In any action pursuant to this subdivision, the commissioner and the superintendent shall take action to assure the continued insurance coverage of enrollees of the organization.

4. In addition to, or in lieu of, any revocation, limitation or annulment, the commissioner may assess a penalty pursuant to section twelve of this chapter for any violation of this chapter or rules and regulations promulgated pursuant to this article.

5. All orders or determinations made in accordance with the provisions of this section shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered mail of a copy of the order or determination upon the

organization.

§ 4405. Health maintenance organizations; powers. The powers of health maintenance organizations, in addition to any other powers conferred by the laws under which such organization is constructed, shall include:

1. subject to the provisions of article twenty-eight of this chapter, the purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

2. the furnishing of comprehensive health care services on a prepaid basis through hospitals and other health care providers which are under contract with, otherwise associated with, or employed by the health maintenance organization;

3. the marketing, enrollment and administration of a comprehensive health services plan;

4. the contracting with an insurer licensed in this state;

5. the offering, in addition to health care services, of benefits covering out-of-area or emergency services;

6. the provision of additional health services not included in the comprehensive health services plan on a fee-for-service basis, the provision of health services on a fee-for-service basis to persons who are not members of the enrolled population;

7. the entering into contracts in furtherance of the purposes of this article;

8. the acceptance from government agencies, private agencies, corporations, associations, groups, individuals, or other persons,

payments covering all or part of the cost of health care services provided to enrollees, in accordance with the provisions of the plan and this chapter; and

9. the indemnification of enrollees for the services of health care providers, other than primary care practitioners responsible for supervising and coordinating the care of enrollees, not participating in a plan to the extent authorized in section forty-four hundred six of this article; and

10. notwithstanding any other provision of law, to advertise the comprehensive health services which it renders and the plan relating to the rendition of such services, provided, however, that all information disseminated to the public shall be strictly factual in nature and accurate in all respects and shall not in any way be misleading to the public.

§ 4405-a. Immunizations against poliomyelitis, mumps, measles, diphtheria and rubella. 1. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization, as defined in this article, to inquire of each person in its care under the age of eighteen, or of a person in parental relation to such person, whether all necessary immunizations have been received for poliomyelitis, mumps, measles, diphtheria and rubella and, if not, to make available such immunizations and a certificate or certificates of such immunizations.

2. This section shall not apply to children whose parent, parents, or guardian are bona fide members of a recognized religious organization whose teachings are contrary to the practices herein required.

3. If any physician licensed to practice medicine in this state certifies that any such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to the child's health.

§ 4405-b. Duty to report. 1. (a) A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this chapter shall make a report to the appropriate professional disciplinary agency within thirty days of the occurrence of any of the following: (i) the termination of a health care provider contract pursuant to section forty-four hundred six-d of this article for reasons relating to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare; (ii) the voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures; or (iii) the termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

(b) An organization shall make a report to be made to the appropriate professional disciplinary agency within thirty days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in article one hundred thirty or one hundred thirty-one-A of the education law. A violation of this subdivision shall not be subject to the provisions of section twelve-b of this chapter.

2. Reports of possible professional misconduct made pursuant to this section shall be made in writing to the appropriate professional disciplinary agency. Written reports shall include the following information:

(a) the name, address, profession and license number of the individual; and

(b) a description of the action taken by the organization including the reason for the action and the date thereof, or the nature of the action or conduct that led to the resignation, termination of contract or withdrawal, and the date thereof stated with sufficient specificity to allow a reasonable person to understand which of the reasons enumerated led to the action of the organization or the resignation or withdrawal of the individual, and, if the reason was an act or omission of the individual, the particular act or omission.

3. (a) Any report or information furnished to an appropriate professional discipline agency in accordance with the provisions of this section shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issued in a pending action or proceeding.

(b) Any person, facility, organization or corporation which makes a report pursuant to this section in good faith without malice shall have immunity from any liability, civil or criminal, for having made such report. For purposes of any proceeding, civil or criminal, the good faith of any person required to make a report shall be presumed.

§ 4406. Health maintenance organizations; regulation of contracts. 1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of one hundred or fewer employees or members, exclusive of spouses and dependents, or to any employee or member of the group, including dependents, applying for such contract at any time throughout the year. An individual direct payment contract shall be issued only in accordance with section four thousand three hundred twenty-eight of the insurance law. The superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum,

complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of this chapter or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four.

2. (a) Upon approval of the commissioner, an organization may implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan pursuant to a contract, employment or other association. The commissioner, in consultation with the superintendent, shall not approve an organization to implement an out-of-plan benefits system unless the organization demonstrates that:

(i) the requirements of this article and any regulations promulgated thereunder have been met and will continue to be met;

(ii) it can establish and maintain a contingent reserve fund of not less than two percent of the entire net premium income for the calendar year of the organization in addition to any other contingent reserve fund required by the commissioner in regulations subject to the approval of the superintendent; and

(iii) it has established mechanisms to ensure and monitor compliance with the provisions of paragraph (b) of this subdivision.

(b) Except as provided in paragraph (c) of this subdivision, an organization may not permit the benefits provided pursuant to such out-of-plan system to exceed ten percent of the total health care expenditures of the organization, as determined on a quarterly basis,

but such limitation shall not apply to individual direct payment contracts issued pursuant to section forty-three hundred twenty-two of the insurance law. In determining the amount of benefits provided in connection with the use of such providers, an organization shall not include benefits provided pursuant to a referral made by a participating provider or benefits provided in emergency situations.

(c) An organization may exceed the ten percent level by up to two percent in any given quarter provided that the organization does not exceed the ten percent level by the end of the following quarter.

(d) If the commissioner determines that an organization has permitted the benefits provided pursuant to an out-of-plan system to exceed ten percent, except as permitted by paragraph (b) or (c) of this subdivision, the commissioner may, where appropriate, assess an organization a civil penalty not to exceed the amount determined by multiplying the percentage permitted in excess of ten percent by the amount, in dollars, of the difference between what the organization paid all inpatient hospitals for such year and the amount such organization would have paid such hospitals had it been a payor within the categories specified in paragraph (b) of subdivision one of section twenty-eight hundred seven-c of this chapter and not authorized to negotiate hospital rates. The commissioner, in consultation with the superintendent, may revoke, suspend or limit an approval issued pursuant to this subdivision for non-compliance by the organization with any of the provisions of this article or the rules and regulations promulgated thereunder.

(e) The indemnification of enrollees of the services of a non-participating provider may be subject to deductibles, copayments and/or coinsurance approved by the superintendent.

(f) Nothing in this subdivision shall be construed to limit an organization's ability to manage the care of enrollees or the types of health services covered, to conduct utilization review of quality assurance activities.

(g) The commissioner may prohibit an organization determined to have an inadequate network of participating providers from permitting new elections pursuant to this subdivision as of the date of notification of such determination by the commissioner. Notification of such action shall be given by the organization to each enrollee.

(h) An organization providing comprehensive health services under one

or more assumed names shall be deemed to be offering its plan through a line of business corresponding to each such assumed name. An organization may, pursuant to the provisions of this subdivision, permit enrollees of one or more lines of business to elect to receive services from providers not participating in such line or lines of business provided, however, that with respect to each line of business such elections shall be permitted only to the extent authorized pursuant to paragraphs (b) and (c) of this subdivision.

(i) Nothing herein shall be deemed to prohibit a health maintenance organization from offering services in connection with a company appropriately licensed pursuant to the insurance law.

3. (a) No contract issued pursuant to this section shall provide that services of a participating hospital will be covered as out-of-network services solely on the basis that the health care provider admitting or rendering services to the enrollee is not a participating provider.

(b) No contract issued pursuant to this section shall provide that services of a participating health care provider will be covered as out-of-network services solely on the basis that the services are rendered in a non-participating hospital.

(c) For purposes of this subdivision, a "health care provider" is a health care professional licensed, registered or certified pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

4. Nothing in this section shall be construed to require a health maintenance organization in its provision of a comprehensive health services plan to meet the requirements of an insurer under the insurance law.

5. If an enrollee requires nursing facility placement and is a resident of a continuing care retirement community authorized under article forty-six of this chapter, the enrollee's primary care practitioner must refer the enrollee to that community's nursing facility if medically appropriate; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for similar services and supplies, or

negotiates a mutually agreed upon rate; and if the facility meets the health maintenance organization's guidelines and standards for the delivery of medical services.

§ 4406-a. Arbitration provisions of health maintenance organization contracts. 1. The enrollee contract of a health maintenance organization may permit enrollees and adult members of the enrollee's family who are covered by such contract to elect to have all claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to the contract by a physician, dentist, hospital, health maintenance organization or other health care provider subject to binding arbitration, pursuant to article seventy-five-A of the civil practice law and rules. For the purposes of this section, "health maintenance organizations" shall include those health maintenance organizations organized pursuant to this article or pursuant to article forty-three of the insurance law. The enrollee contract may permit arbitration elections to be executed on behalf of minor children or persons judicially determined to be incompetent by a parent, legal guardian, committee or conservator or other person legally authorized to enroll the minor or incompetent person in a health maintenance organization. Arbitration election notices, described in subdivisions two and three of this section, must be executed by covered adult family members in order to bind such persons to the arbitration election.

2. After receiving the approval of the superintendent of financial services, pursuant to section five thousand six hundred five of the insurance law, health maintenance organizations may provide arbitration election notices to current enrollees and their covered adult family members. Such notice shall contain the following provision in at least twelve point boldface type immediately above spaces for the signature of the enrollee or covered adult family member: "By signing this form, I am agreeing to have any issue of alleged health care malpractice decided by neutral arbitration rather than by a court trial before a judge or jury. (Health care malpractice means claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to my health maintenance organization contract by the

health maintenance organization, a physician, dentist, hospital or other health care provider.) I understand that I will be given the opportunity to cancel my agreement, but that all claims arising during the time of my agreement will be subject to arbitration. I understand that by signing the form, I am deemed to have received and reviewed the information describing arbitration that has been provided to me. I also understand that there is no requirement that I sign this form and that my decision not to sign this form will not in any way affect my membership or benefits in this health maintenance organization."

3. After receiving the approval of the superintendent of financial services, pursuant to section five thousand six hundred five of the insurance law, health maintenance organizations may also provide arbitration election notices, as specified in subdivision two of this section, to new enrollees and their covered adult family members. In the alternative, a health maintenance organization may, after receiving the superintendent's approval, elect to provide an alternative notice to new enrollees and their covered adult family members that provides that new enrollees and their covered adult family members shall be subject to the arbitration of claims unless a form is executed by such persons that declines consent to the arbitration of claims. A health maintenance organization that chooses to provide such alternative notice shall provide an arbitration declination form and notice to all new enrollees and their covered adult family members with the following provision in a least twelve point boldface type immediately above spaces for the signature of the enrollee or covered adult family member: "Unless you sign this form to decline the option of arbitration, by electing to enroll in this health maintenance organization, you are agreeing to have any issue of health care malpractice decided by neutral arbitration rather than by a court trial before a judge or jury. (Health care malpractice means all claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered pursuant to your health maintenance organization contract by the health maintenance organization, a physician, dentist, hospital or other health care provider.) If you do not sign this form to decline arbitration, you will be given the opportunity to cancel your agreement to arbitrate these claims, but all claims arising prior to the time that

you cancel the agreement will be subject to arbitration. You are entitled to receive information describing arbitration before making this decision. Your decision to sign this form to decline arbitration will not in any way affect your membership or benefits in this health maintenance organization."

4. Arbitration election notices may be provided, from time to time, by health maintenance organizations to persons who have not agreed to arbitration of such claims. The health maintenance organizations shall, in a form and manner determined to be sufficient by the superintendent of financial services and on at least an annual basis, provide notice to persons who have agreed to arbitration of such claims that such persons may cancel their agreement to arbitrate, including information as to how such person may cancel the arbitration agreement; provided, however, that the agreement to arbitrate shall remain in force during such person's enrollment or membership in the health maintenance organization unless the health maintenance organization receives notification of such person's cancellation of the arbitration agreement or the health maintenance organization withdraws its agreement to arbitrate and provides notice of this fact to persons who elected arbitration.

5. Every such notice shall be accompanied by or be part of an information brochure, prepared in accordance with section five thousand six hundred four of the insurance law, which clearly explains the nature and scope of arbitration and the procedures that will be used to conduct these arbitration proceedings.

6. All claims arising from surgical, medical, dental and other health care procedures performed or failed to be performed and treatment provided or failed to be provided by a physician, dentist, hospital, health maintenance organization or other health care provider pursuant to the enrollee contract to an enrollee or a covered adult family member who signs the arbitration election notice or who fails to sign the arbitration declination form specified in subdivision three of this section shall be subject to arbitration and such enrollees or covered adult family members shall be bound by the agreement to arbitrate such claims. All physicians, dentists, hospitals, health maintenance

organizations and other health care providers who provide or receive compensation for health care services pursuant to the enrollee contract shall be bound by the agreement to arbitrate.

7. Notwithstanding any inconsistent provisions of law, an agreement to arbitrate which complies with the provisions of this section shall be presumed valid.

§ 4406-b. Primary and preventive obstetric and gynecologic care. 1.

The health maintenance organization shall not limit a female enrollee's direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy, provided that: (a) such qualified provider discusses such services and treatment plan with the enrollee's primary care practitioner in accordance with the requirements of the health maintenance organization; and (b) such qualified provider agrees to adhere to the health maintenance organization's policies and procedures, including any applicable procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan (if any) approved by the health maintenance organization.

2. A health maintenance organization shall treat the provision of obstetric and gynecologic care, and the ordering of related obstetric and gynecologic items and services, pursuant to the direct access described in subdivision one of this section by a participating qualified provider of such services, as the authorization of the primary care provider.

3. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization to advise each female enrollee, in writing, of the provisions of this section.

§ 4406-c. Prohibitions. 1. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article or a medical group.

2. No health care plan shall by contract or written policy or written procedure prohibit or restrict any health care provider from disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, (hereinafter collectively referred to as enrollee) any information that such provider deems appropriate regarding:

(a) a condition or a course of treatment with an enrollee including the availability of other therapies, consultations, or tests; or

(b) the provisions, terms, or requirements of the health care plan's products as they relate to the enrollee, where applicable.

3. No health care plan shall by contract, written policy, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall a health care plan take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such health care plan which may violate this chapter or the insurance law including subsection (g), (k), (l), (l-1) or (l-2) of section forty-three hundred three of the insurance law.

4. No health care plan shall by contract, written policy or written procedure prohibit or restrict any health care provider from advocating to the health care plan on behalf of the enrollee for approval or coverage of a particular course of treatment or for the provision of

health care services.

5. No contract or agreement between a health care plan and a health care provider shall contain any clause purporting to transfer to the health care provider, other than a medical group, by indemnification or otherwise any liability relating to activities, actions or omissions of the health care plan as opposed to those of the health care provider.

5-a. Contracts entered into between a plan and a health care provider shall include terms which prescribe:

(a) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(b) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(c) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(d) the process to be employed to resolved disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and

(e) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contract through a proceeding under article seventy-five of the civil practice law and rules.

5-b. No contract entered into with health care providers shall be enforceable if it includes terms which transfer financial risk to

providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of section forty-four hundred three of this article, or penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

5-c. (a) No health care plan shall implement an adverse reimbursement change to a contract with a health care professional that is otherwise permitted by the contract, unless, prior to the effective date of the change, the health care plan gives the health care professional with whom the health care plan has directly contracted and who is impacted by the adverse reimbursement change, at least ninety days written notice of the change. If the contracting health care professional objects to the change that is the subject of the notice by the health care plan, the health care professional may, within thirty days of the date of the notice, give written notice to the health care plan to terminate his or her contract with the health care plan effective upon the implementation date of the adverse reimbursement change. For the purposes of this subdivision, the term "adverse reimbursement change" shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional, and the term "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law. The notice provisions required by this subdivision shall not apply where: (i) such change is otherwise required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or (ii) such change is expressly provided for under the terms of the contract by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

(b) Nothing in this subdivision shall create a private right of action on behalf of a health care professional against a health care plan for

violations of this subdivision.

* 5-d. If a contract between a plan and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of such contract, including reimbursement terms, for a period of two months from the effective date of termination or, in the case of a non-renewal, from the end of the contract period. Notice shall be provided to all enrollees potentially affected by such termination or non-renewal within fifteen days after commencement of the two-month period. The commissioner shall have the authority to waive the two-month period upon the request of either party to a contract that is being terminated for cause. This subdivision shall not apply where both parties mutually agree in writing to the termination or non-renewal and the plan provides notice to the enrollee at least thirty days in advance of the date of contract termination.

* NB Repealed June 30, 2027

5-e. At least sixty days prior to the termination of a contract between a hospital and a health care plan, the parties shall utilize a mutually agreed upon mediator to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

6. No health care plan which provides coverage for prescription drugs shall require, or enter into a contract which permits, a copayment which exceeds the usual and customary cost of such prescribed drug.

* 7. No health maintenance organization which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).

* NB There are 2 sub 7's

* 7. Any contract provision, written policy or written procedure in violation of this section shall be deemed to be void and unenforceable.

* NB There are 2 sub 7's

8. (a) No health care plan shall by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of this chapter for a claim for medically necessary inpatient services, observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not comply with certain administrative requirements of such health care plan with respect to those services.

(b) Nothing in this subdivision shall preclude a general hospital and a health care plan from agreeing to certain administrative requirements relating to payment for inpatient services, observation services, or emergency department services, including, but not limited to, timely notification that medically necessary inpatient services have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely notification; provided, however that: (i) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for services provided on weekends or federal holidays, (ii) any agreed to reduction in payment for failure to meet administrative requirements, including timely notification shall not exceed seven and one-half percent of the payment amount otherwise due for the service provided, and (iii) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's coverage could not be determined by the hospital after reasonable efforts at the time the services were provided.

(c) The provisions of this subdivision shall not apply to the denial of a claim: (i) based on a reasonable belief of a health care plan of fraud or intentional misconduct resulting in a misrepresentation of patient diagnosis or the services provided, or abusive billing; (ii) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; (iii) that is a duplicate claim, is a claim submitted late pursuant to subsection (g) of section thirty-two hundred twenty-four-a of the insurance law, or is for services for a benefit that is not covered under the insured's contract or for a patient determined to be ineligible for coverage; (iv) except in the

case of medically necessary inpatient services resulting from an emergency admission, where there is not an existing participating provider agreement between a health care plan and a general hospital; or (v) where the hospital has repeatedly and systematically, over the previous twelve month period, failed to seek prior authorization for services for which prior authorization was required.

(d) For purposes of this subdivision, an "administrative requirement" shall not include requirements: (i) imposed on a health care plan or provider pursuant to federal or state laws, regulations or guidance; or (ii) established by the state or federal government applicable to health care plans offering benefits under a state or federal government program.

(e) The prohibition on denials set forth in this subdivision shall not apply to claims for services for which a request for preauthorization was denied by the health care plan prior to delivery of the service.

9. A health care plan shall not require a prior authorization determination for services provided in a neonatal intensive care unit of a general hospital certified pursuant to article twenty-eight of this chapter. Nothing in this subdivision shall prohibit a health care plan from denying a claim for such services if the services are subsequently determined not medically necessary.

10. (a) Any contract or other arrangement entered into by a health care plan for the provision and administration of pharmacy benefit management services on behalf of individuals enrolled in a managed care provider, as defined in section three hundred sixty-four-j of the social services law, shall be based on a pass-through pricing model and include the following requirements:

(i) Payment to the pharmacy benefit manager for pharmacy benefit management services shall be limited to the actual ingredient costs, dispensing fees paid to pharmacies, and an administrative fee that covers the cost of providing pharmacy benefit management services pursuant to a contract described in this paragraph. The department may establish a maximum administrative fee;

(ii) The pharmacy benefit manager shall identify all sources and amounts of income, payments, and financial benefits to the pharmacy

benefit manager related to the provision and administration of pharmacy benefit management services on behalf of the health care plan, including, but not limited to, any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits and shall ensure that any portion of such income, payments, and financial benefits is passed through to the health care plan in full to reduce the reportable ingredient cost;

(iii) The pharmacy benefit manager shall fully disclose to the department and to the health care plan the sources and amounts of all income, payments, and financial benefits referred to in subparagraph (ii) of this paragraph received by the pharmacy benefit manager;

(iv) The pharmacy benefit manager shall identify all ingredient costs and dispensing fees or similar payments made by the pharmacy benefit manager to any pharmacy in connection with the contract or other arrangement;

(v) The pharmacy benefit manager shall not utilize any form of spread pricing in any contract or other arrangement with health care plans. For purposes of this subdivision "spread pricing" means any amount charged or claimed by the pharmacy benefit manager in excess of the amount paid to pharmacies on behalf of the health care plan less an administrative fee as described in this paragraph. Any such excess amount shall be remitted to the health care plan on a quarterly basis;

(vi) Pharmacy benefit managers shall make their payment model for administrative fees available to the health care plan and to the department. The health care plan shall, if so directed by the department, make changes to the payment model and resubmit an amended contract or contracts to the department for review and approval.

(b) Any changes to premiums resulting from such contracts shall be subject to certification by the state's actuary as actuarially appropriate.

(c) Contracts or other arrangements subject to this subdivision shall be submitted to the department for review and approval as required by and in accordance with state law and the regulations of the department. Contracts or other arrangements subject to this subdivision existing and in force at the time of enactment of this subdivision shall be submitted to the department for review and approval on or before July first, two

thousand nineteen.

11. A contract between a health care plan and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the health care plan. A health care provider shall submit such provider directory information to a health care plan, at a minimum, when a provider begins or terminates a network agreement with a health care plan, when there are material changes to the content of the provider directory information of such health care provider, and at any other time, including upon the health care plan's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

12. A contract between a health care plan and a health care provider shall include a provision that states that the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the commissioner in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the enrollee is provided with inaccurate network status information by the health care plan in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the health care plan provides inaccurate network status information to the enrollee indicating the provider was a participating provider when such provider was not a participating provider, the health care plan shall reimburse the provider for the out-of-network services regardless of whether the

enrollee's coverage includes out-of-network services. Nothing in this subdivision shall prohibit a health care provider from requiring in the terms of a contract with a health care plan that the health care plan remove, at the time of termination of such contract, the provider from the health care plan's provider directory or that the health care plan bear financial responsibility for providing inaccurate network status information to an enrollee.

13. (a) No contract or agreement between a health plan subject to this article and a health care provider, other than a residential health care facility as defined by section twenty-eight hundred one of this chapter, shall include a provision that:

(i) contains a most-favored-nation provision; or

(ii) restricts the ability of a health plan, an entity that contracts with a health care plan for a provider network, or a health care provider to disclose: (A) actual claims costs; or (B) price or quality information required to be disclosed under federal law, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations, including, but not limited to, patient cost-sharing covered by the provider contract to any subscriber, enrollee, group, or other entity receiving health care services pursuant to the contract, or to any public compilation of reimbursement data such as the New York all payer database required by law or regulation, provided that no disclosure shall include protected health information or other information covered by statutory or other privilege.

(b) For purposes of this subdivision, the term "health plan" shall include:

(i) an insurer licensed pursuant to the insurance law or a health maintenance organization certified pursuant to this article; and

(ii) a third-party administrator, affiliated with an insurer or health maintenance organization, who administers a health benefit plan.

14. (a) A health care plan may pay a claim for reimbursement made by a provider using a credit card, virtual credit card, or electronic funds transfer payment method that imposes on the provider a specifically identified fee or similar dedicated charge to process the payment if in advance of using such reimbursement method:

(i) The health care plan notifies the provider of the potential fees or other charges associated with the use of the credit card, virtual credit card, or electronic funds transfer payment;

(ii) The health care plan offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(iii) The provider or a designee of the provider elects to accept payment of the claim using the credit card, virtual credit card, or electronic funds transfer payment method. Such payment type election shall be made by the provider within thirty days of receipt of the notice from the insurer. If the provider fails to make any payment type election within thirty days, the insurer shall pay the provider using the alternative payment method offered in the notice unless the insurer is unable to pay the provider using that alternative method due to the insurer lacking information necessary to make the alternative payment. In that instance, the insurer may use another fee-free method of payment in order to meet the timeframes established in section three thousand two hundred twenty-four-a of the insurance law.

(b) A decision pursuant to paragraph (a) of this subdivision shall remain in effect until the provider notifies the health care plan, in writing, of a change to the designated payment type.

(c) If a health care plan contracts with a vendor to process payments of providers' claims, the health care plan shall require the vendor to comply with the provisions of paragraph (a) of this subdivision. This paragraph shall not apply to a vendor used by the provider in order to receive payments from an insurer.

(d) No contract between a health care plan and provider issued, renewed, modified, altered or amended after the effective date of this subdivision shall contain provisions allowing for waiver of the notice requirements contained in this subdivision.

(e) For any contract that is in effect on or before the effective date of this subdivision or that is entered into, amended or renewed on or after the effective date of this subdivision, a health care plan that initiates a payment to a provider using, or changes the payment method to, a health care electronic funds transfers and remittance advice transaction shall not charge a fee solely to transmit the payment to the provider unless the provider elects to accept payment in accordance with subparagraph (iii) of paragraph (a) of this subdivision.

(f) For purposes of this subdivision, the following definitions shall apply:

(i) "Provider" shall mean a health care professional or a group of health care professionals licensed pursuant to title eight of the education law that has a participating provider contract with a health care plan to provide health care services to an enrollee.

(ii) "Virtual credit card" shall mean a single-use series of numbers linked to a fixed dollar amount and provided by a health care plan to a provider for the purpose of paying a claim for health care services performed by the provider.

§ 4406-d. Health care professional applications and terminations. 1.

(a) A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. A health care plan shall complete review of the health care professional's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a health care professional's completed application to participate in the health care plan's network, notify the health care professional as to: (i) whether he or she is credentialed; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(b) If the completed application of a newly-licensed health care professional or a health care professional who has recently relocated to this state from another state and has not previously practiced in this state, who joins a group practice of health care professionals each of whom participates in the in-network portion of a health care plan's network, is neither approved nor declined within sixty days of

submission of a completed application pursuant to paragraph (a) of this subdivision, the health care professional shall be deemed "provisionally credentialed" and may participate in the in-network portion of the health care plan's network; provided, however, that a provisionally credentialed physician may not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed. The network participation for a provisionally credentialed health care professional shall begin on the day following the sixtieth day of receipt of the completed application and shall last until the final credentialing determination is made by the health care plan. A health care professional shall only be eligible for provisional credentialing if the group practice of health care professionals notifies the health care plan in writing that, should the application ultimately be denied, the health care professional or the group practice: (i) shall refund any payments made by the health care plan for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the enrollee's contract with the health care plan; and (ii) shall not pursue reimbursement from the enrollee, except to collect the copayment that otherwise would have been payable had the enrollee received services from a health care professional participating in the in-network portion of a health care plan's network. Interest and penalties pursuant to section three thousand two hundred twenty-four-a of the insurance law shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent a health care plan from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim. A health care plan shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

(c) A newly-licensed physician, a physician who has recently relocated to this state from another state and has not previously practiced in this state, or a physician who has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which such physician's services are billed for and who previously had a participation contract with the health care

plan immediately prior to the event that changed his or her corporate relationship, who becomes employed by a general hospital or diagnostic and treatment center licensed pursuant to article twenty-eight of this chapter, or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law which has a participating provider contract with a health care plan, and whose other employed physicians participate in the in-network portion of a health care plan's network, shall be deemed "provisionally credentialed" and may participate in the in-network portion of a health care plan's network during this time period upon: (i) the health care plan's receipt of the hospital and physician's completed sections of the insurer's credentialing application; and (ii) the health care plan being notified in writing that the health care professional has been granted hospital privileges pursuant to the requirements of section twenty-eight hundred five-k of this chapter. However, a provisionally credentialed physician shall not be designated as an enrollee's primary care physician until such time as the physician has been fully credentialed by the health care plan. Notwithstanding any other provision of law, a health care plan shall not be required to make any payments to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the service provided by a provisionally credentialed physician, until and unless the physician is fully credentialed by the health care plan, provided, however, that upon being fully credentialed, the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall be paid for all services provided by the physician for up to sixty days after submission of the completed application that the credentialed physician provided to the health care plan's insureds from the date the physician fully met the requirements to be provisionally credentialed pursuant to this paragraph. Should the application ultimately be denied by the health care plan, the health care plan shall not be liable for any payment to the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law for the services provided by the provisionally credentialed

health care professional; and the licensed general hospital, the licensed diagnostic and treatment center or a facility licensed under article sixteen, article thirty-one or article thirty-two of the mental hygiene law shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance or deductible amount that otherwise would have been payable had the insured received services from a health care professional participating in the in-network portion of a health care plan's network.

2. (a) A health care plan shall not terminate a contract with a health care professional unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This section shall not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

(b) The notice of the proposed contract termination provided by the health care plan to the health care professional shall include:

(i) the reasons for the proposed action;

(ii) notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by the health care plan;

(iii) a time limit of not less than thirty days within which a health care professional may request a hearing; and

(iv) a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

(c) The hearing panel shall be comprised of three persons appointed by the health care plan. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(d) The hearing panel shall render a decision on the proposed action in a timely manner. Such decision shall include reinstatement of the health care professional by the health care plan, provisional

reinstatement subject to conditions set forth by the health care plan or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(e) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision; provided, however, that the provisions of paragraph (e) of subdivision six of section four thousand four hundred three of this article shall apply to such termination.

(f) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

3. Either party to a contract may exercise a right of non-renewal at the expiration of the contract period set forth therein or, for a contract without a specific expiration date, on each January first occurring after the contract has been in effect for at least one year, upon sixty days notice to the other party; provided, however, that any non-renewal shall not constitute a termination for purposes of this section.

4. A health care plan shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate the performance or practice of the health care professional. The health care plan shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. Health care plans shall provide any such information and profiling data and analysis to health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing

on the health care professional's profile and to work cooperatively with the health care plan to improve performance.

5. No health care plan shall terminate a contract or employment, or refuse to renew a contract, solely because a health care provider has:

- (a) advocated on behalf of an enrollee;
- (b) filed a complaint against the health care plan;
- (c) appealed a decision of the health care plan;
- (d) provided information or filed a report pursuant to section forty-four hundred six-c of this article; or
- (e) requested a hearing or review pursuant to this section.

6. Except as provided herein, no contract or agreement between a health care plan and a health care professional shall contain any provision which shall supersede or impair a health care professional's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination.

7. Any contract provision in violation of this section shall be deemed to be void and unenforceable.

8. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article.

9. For purposes of this section, "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

§ 4406-e. Access to end of life care. 1. For the purposes of this section, "health care plan" means a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article.

2. Every health care plan that provides coverage for hospital, surgical or medical care that includes coverage for acute care services shall provide an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) with coverage for acute care services at an acute care facility licensed pursuant to article twenty-eight of this chapter specializing in the treatment of terminally ill patients, if the patient's attending health care practitioner, in consultation with the medical director of the facility, determines that the enrollee's care would appropriately be provided by the facility.

3. Notwithstanding the provisions of article forty-nine of this chapter, if the health care plan disagrees with the admission of or provision or continuation of care for the enrollee by the facility, the health care plan shall initiate an expedited external appeal in accordance with the provisions of paragraph (c) of subdivision two of section forty-nine hundred fourteen of this chapter, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by the health care plan and the health care plan shall provide coverage and reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract. The decision of the external appeal agent shall be binding on all parties. If the health care plan does not initiate an expedited external appeal, the health care plan shall reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract.

4. A health care plan shall provide reimbursement for those services prescribed by this section at rates negotiated between the health care plan and the facility. In the absence of agreed upon rates, a health care plan shall pay for acute care at the facility's acute care rate under the Medicare program (Title XVIII of the federal Social Security Act), including the Part A rate for Part A services and the Part B rate for Part B services, and shall pay for alternate level care days at

seventy-five percent of the acute care rate, including the Part A rate for Part A services and the Part B rate for Part B services.

5. Payment by a health care plan pursuant to this section shall be payment in full for the services provided to the enrollee. An acute care facility reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an enrollee for the services provided by the acute care facility pursuant to this section, except for the collection of copayments, coinsurance or visit fees, or deductibles for which the enrollee is responsible under the terms of the applicable contract.

6. No provision of this section shall be construed to require a health care plan to provide coverage for benefits not otherwise covered under the enrollee's contract.

§ 4406-f. Maternal depression screenings. To the extent a plan provides coverage for maternal depression screening, no health maintenance organization subject to this article shall by contract, written policy or procedure limit a patient enrollee's direct access to screening and referral for maternal depression, as defined in subdivision one of section twenty-five hundred-k of this chapter, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the patient enrollee's access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the plan under which the patient enrollee is covered.

§ 4406-g. Telehealth delivery of services. 1. A health maintenance organization shall not exclude from coverage a service that is otherwise covered under an enrollee contract of a health maintenance organization because the service is delivered via telehealth, as that term is defined in subdivision two of this section; provided, however, that a health maintenance organization may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the enrollee contract. A health maintenance organization may subject the

coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the enrollee as those established for the same service when not delivered via telehealth. A health maintenance organization may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

2. For purposes of this section, "telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an enrollee while such enrollee is located at a site that is different from the site where the health care provider is located.

* 3. A health maintenance organization that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered via telehealth on the same basis, at the same rate, and to the extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered by means of telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The commissioner, in consultation with the superintendent, may promulgate regulations to implement the provisions of this section.

* NB Repealed April 1, 2028

* 4. A health maintenance organization that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

* NB Repealed April 1, 2028

§ 4406-h. Health care facility applications. 1. A health care plan shall, upon request, make available and disclose to facilities written

application procedures and minimum qualification requirements that a facility must meet in order to be considered by the health care plan for participation in the in-network benefits portion of the health care plan's network. The health care plan shall consult with appropriately qualified facilities in developing its qualification requirements. A health care plan shall complete review of the facility's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a facility's completed application to participate in the health care plan's network, notify the facility as to: (a) whether the facility is credentialed; or (b) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health care plan shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

2. For the purposes of this section, "facility" shall mean a health care provider entity or organization that is licensed or certified pursuant to article five, twenty-eight, thirty-six, forty, forty-four, or forty-seven of this chapter or article sixteen, nineteen, thirty-one, thirty-two, or thirty-six of the mental hygiene law.

§ 4406-i. Utilization review determinations for medically fragile children. 1. Notwithstanding any inconsistent provision of the health maintenance organization's clinical standards, the health maintenance organization, and any utilization review agent under contract with such health maintenance organization, shall administer and apply the clinical standards (and make determinations of medical necessity) regarding medically fragile children in accordance with the requirements of this section and any regulations with special considerations and processes for utilization review related to medically fragile children.

2. Health maintenance organizations shall undertake the following with respect to medically fragile children, and as applicable, shall ensure

that their contracted utilization review agents undertake the following with respect to medically fragile children:

(a) Consider as medically necessary all covered services that assist medically fragile children in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. In the case of Medicaid managed care, health maintenance organizations shall continue to cover services until that child achieves age-appropriate functional capacity.

(b) Shall not base determinations solely upon review standards applicable to (or designed for) adults to medically fragile children. Determinations shall take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

(c) Accommodate unusual stabilization and prolonged discharge plans for medically fragile children, as appropriate. Health maintenance organizations, and as applicable their contracted utilization review agents, shall consider when developing and approving discharge plans issues including sudden reversals of condition or progress which may make discharge decisions uncertain or more prolonged than for other children or adults.

(d) It is the health maintenance organization's network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility. In the case of Medicaid managed care, payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the utilization review agent to identify an appropriate provider.

(e) This section does not limit any other rights the medically fragile child may have, including the right to appeal the denial of out of network coverage at in-network cost sharing levels where an appropriate in-network provider is not available pursuant to subdivision one-b of section forty-nine hundred four of this chapter.

(f) Health maintenance organizations shall contract with providers with demonstrated expertise in caring for the medically fragile children. Network providers shall refer to appropriate network community and facility providers for covered services to meet the needs of the child or seek authorization from the health maintenance

organization for out-of-network providers when participating providers cannot meet the child's needs.

3. In the case of Medicaid managed care, when rendering or arranging for care or payment, both the provider and the health maintenance organization shall inquire of, and shall consider the desires of the family of a medically fragile child including, but not limited to, the availability and capacity of the family, the need for the family to simultaneously care for the family's other children, and the need for parents to continue employment.

4. In the case of Medicaid managed care, the health maintenance organization shall pay for all days of inpatient hospital care at a participating specialty care center for medically fragile children when the health maintenance organization and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place, or the patient is awaiting discharge to a residential health care facility when no residential health care facility bed is available given the specialized needs of the medically fragile child. In the case of Medicaid managed care, the health maintenance organization shall pay, for all days of residential health care facility care at a participating specialty care center for medically fragile children when the health maintenance organization and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place. In the case of Medicaid managed care, such requirements shall apply until the health plan can identify and secure admission to an alternate provider rendering the necessary level of services. The specialty care center shall facilitate placement efforts to effectuate the discharge.

5. In the event a health maintenance organization enters into a participation agreement with a specialty care center for medically fragile children in this state, the requirements of this section shall apply to such participation agreement and to all claims submitted to, or payments made by, any other health maintenance organizations, insurers

or payors making payment to the specialty care center pursuant to the provisions of that participation agreement.

§ 4407. Health maintenance organizations; employer requirements. 1. All employers subject to the provisions of the unemployment insurance law, except for those employers with fewer than twenty-five employees, shall include in any health benefits plan offered to their employees, the option of membership in a health maintenance organization which provides or offers a comprehensive health services plan in accordance with the provisions of this article, but only if such plan serves an area in which twenty-five of such employer's employees reside and the organization has been issued a certificate of authority by the commissioner.

2. For those employees of an employer represented by a bargaining representative, the offer of the health maintenance organization alternative shall be subject only to the collective bargaining process; for those employees not represented by a bargaining representative, the offer of the health maintenance organization alternative shall be made directly to the employee.

3. (a) If there is more than one health maintenance organization engaged in the provision of health services in the area in which the employees of the employer reside, and if:

(i) one or more of such organizations provides more than one-half of its comprehensive health services through physicians or other health professionals who are members of the staff of the organization or of a medical group (or groups) which contracts with the organization, and

(ii) one or more of such organizations provides its comprehensive health services through contracts with an individual practice association (or associations), individual physicians and other health professionals under contract directly with the organization, or a combination of an individual practice association (or associations), medical group (or groups), physicians who are members of the staff of the organization, and individual physicians and other health professionals under contract directly with the organization,

then the employer shall, in accordance with regulations of the commissioner, be required to offer the option of enrollment in at least one organization described in subparagraph (i) of this paragraph and at least one organization described in subparagraph (ii) of this paragraph if the employer has twenty-five or more but fewer than two hundred employees. If the employer has two hundred or more employees and the employer's principal office in this state is located outside of the metropolitan region then the employer shall be required to offer the option of enrollment in at least two organizations described in subparagraph (i) of this paragraph and at least two organizations described in subparagraph (ii) of this paragraph. If the employer has two hundred or more employees and the employer's principal office in this state is located within the metropolitan region then the employer shall be required to offer the option of enrollment in at least two organizations described in subparagraph (i) of this paragraph and at least two organizations described in subparagraph (ii) of this paragraph and an additional organization from either subparagraph. For the purposes of this section the metropolitan region is defined as the counties of Westchester, Rockland, New York, Kings, Queens, Richmond, Bronx, Nassau and Suffolk.

(b) If within any particular area of the state in which at least twenty-five of such employer's employees reside there are fewer health maintenance organizations described in subparagraph (i) or (ii) of paragraph (a) of this subdivision than the employer is required to offer, then additional health maintenance organizations from subparagraph (i) or (ii) of paragraph (a) of this subdivision shall be offered; provided, however, that no employer with fewer than two hundred employees shall be required to offer more than a total of two health maintenance organizations, and no employer with two hundred or more employees shall be required to offer more than a total of four health maintenance organizations (or five such organizations if the employer's principal office is located within the metropolitan region) in any particular area of the state. In the event fewer than the required total minimum number of health maintenance organizations are available in an area, the employer shall offer all health maintenance organizations then certified to issue subscriber contracts in that area. Nothing in this subdivision shall be deemed to prohibit an employer from

choosing to offer more health maintenance organizations to its employees than are required under this subdivision.

4. No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between an employer and his employees.

§ 4408. Disclosure of information. 1. Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook or the subscriber contract or certificate containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

(a) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(b) a description of all prior authorization or other requirements for treatments and services;

(c) a description of utilization review policies and procedures used by the health maintenance organization, including:

(i) the circumstances under which utilization review will be undertaken;

(ii) the toll-free telephone number of the utilization review agent;

(iii) the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(iv) the right to reconsideration;

(v) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(vi) the right to designate a representative;

(vii) a notice that all denials of claims will be made by qualified

clinical personnel and that all notices of denials will include information about the basis of the decision;

(viii) a notice of the right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the timeframes for such appeals; and

(ix) further appeal rights, if any;

(d) a description prepared annually of the types of methodologies the health maintenance organization uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a health maintenance organization and a health care provider;

(e) an explanation of a subscriber's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a subscriber's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services provided within the health maintenance organization;

(f) an explanation of a subscriber's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization or by any provider without required authorization or when a procedure, treatment or service is not a covered health care benefit;

(g) a description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including: the right to file a grievance regarding any dispute between an enrollee and a health maintenance organization; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which enrollees may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and

circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(h) a description of the procedure for providing care and coverage twenty-four hours a day for emergency services. Such description shall include a definition of emergency services; notice that emergency services are not subject to prior approval; and shall describe the enrollee's financial and other responsibilities regarding obtaining such services including when such services are received outside the health maintenance organization's service area;

(i) a description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(j) a description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(k) notice that an enrollee may obtain a referral to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider who is geographically accessible to the enrollee and who has appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(l) notice that an enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(m) notice that an enrollee with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care and the procedure for requesting and obtaining such a specialist;

(n) notice that an enrollee with a (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease either

of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(o) a description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(p) a description of how the health maintenance organization addresses the needs of non-English speaking enrollees;

(p-1) notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

(q) notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (i) whether the provider is accepting new patients; (ii) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and (iii) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance organization's website and the health maintenance organization shall update the website within fifteen days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

(s) where applicable, a description of the method by which an enrollee may submit a claim for health care services;

(t) with respect to out-of-network coverage:

(i) a clear description of the methodology used by the health maintenance organization to determine reimbursement for out-of-network

health care services;

(ii) the amount that the health maintenance organization will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

(iii) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

(u) information in writing and through an internet website that reasonably permits an enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health maintenance organization will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services; and

(v) the most recent comparative analysis performed by the health maintenance organization to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amendments to, and federal guidance and regulations issued under, those Acts.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee:

(a) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(b) provide a copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(c) provide a copy of the most recent individual, direct pay subscriber contracts;

(d) provide information relating to consumer complaints compiled pursuant to section two hundred ten of the insurance law;

(e) provide the procedures for protecting the confidentiality of medical records and other enrollee information;

(f) allow enrollees and prospective enrollees to inspect drug formularies used by such health maintenance organization; and provided further, that the health maintenance organization shall also disclose whether individual drugs are included or excluded from coverage to an enrollee or prospective enrollee who requests this information;

(g) provide a written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(h) provide a description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(i) provide individual health practitioner affiliations with participating hospitals, if any;

(j) upon written request, provide specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination pursuant to subdivisions three-a, three-b and three-c of section forty-nine hundred three of this chapter, and, where appropriate, other clinical information which the organization might consider in its utilization review and the organization may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the organization, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization. Such clinical review criteria, and other clinical information shall also be made available to a health care professional as defined in subdivision six of section forty-nine hundred of this chapter, on behalf of an enrollee and upon written request;

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act;

(m) disclose whether a health care provider scheduled to provide a

health care service is an in-network provider; and

(n) with respect to out-of-network coverage, disclose the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service. The health maintenance organization shall also inform an enrollee through such disclosure that such approximation is not binding on the health maintenance organization and that the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service may change.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

4. If a primary care provider ceases participation in the health maintenance organization, the organization shall provide written notice within fifteen days from the date that the organization becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and the health maintenance organization is aware of such ongoing course of treatment, the health maintenance organization shall provide written notice within fifteen days from the date that the health maintenance organization becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care pursuant to paragraphs (e) and (f) of subdivision six of section four thousand four hundred three of this article and for choosing an alternative provider.

5. Every health maintenance organization shall annually on or before April first, file a report with the commissioner and superintendent of financial services showing its financial condition as of the last day of the preceding calendar year, in such form and providing such information as the commissioner shall prescribe.

6. Every health maintenance organization offering to indemnify enrollees pursuant to subdivision nine of section forty-four hundred

five and subdivision two of section forty-four hundred six of this article shall on a quarterly basis file a report with the commissioner and the superintendent of financial services showing the percentage utilization for the preceding quarter of non-participating provider services in such form and providing such other information as the commissioner shall prescribe.

7. For purposes of this section, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of financial services. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to this article.

* 8. Every contract delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall provide space on any enrollment, renewal or initial online portal process setup forms required of a subscriber or applicant for coverage, excepting forms issued by the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of paragraph (a) of subdivision five of section forty-three hundred ten and paragraph (v) of subdivision one of section two hundred six of this chapter, so that the subscriber or applicant for coverage shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment or renewal form and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

* NB There are 2 sb 8's

* 8. (a) As used in this subdivision:

(i) "Pharmacy benefit manager" shall have the meaning set forth in section two hundred eighty-a of this chapter.

(ii) "Cost-sharing information" means the amount a subscriber is required to pay to receive a drug that is covered under the subscriber's insurance contract.

(iii) "Covered/coverage" means those health care services to which a subscriber is entitled under the terms of the subscriber contract.

(iv) "Electronic health record" means a digital version of a patient's paper chart and medical history that makes information available instantly and securely to authorized users.

(v) "Electronic prescribing system" means a system that enables prescribers to enter prescription information into a computer prescription device and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network.

(vi) "Electronic prescription" shall have the meaning set forth in section thirty-three hundred two of this chapter.

(vii) "Prescriber" means a health care provider licensed to prescribe medication or medical devices in this state.

(viii) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (1) is capable of integrating with prescribers' electronic prescribing system and, if feasible, electronic health record systems; and (2) complies with the technical standards adopted by an American National Standards Institute (ANSI) accredited standards development organization.

(ix) "Authorized third party" shall include a third party legally authorized under state or federal law subject to a Health Insurance Portability and Accountability Act (HIPAA) business associate agreement.

(b) The provisions of this section shall not apply to any health plan that exclusively serves individuals enrolled pursuant to a federal or state insurance affordability program, including the medical assistance program under title eleven of article five of the social services law, child health plus under section twenty-five hundred eleven of this chapter, the basic health program under section three hundred sixty-nine-gg of the social services law, or a plan providing services under title XVIII of the federal social security act.

(c) A health maintenance organization or pharmacy benefit manager shall, upon request of the subscriber, the subscriber's health care provider, or an authorized third party on the subscriber's behalf, made

to the health maintenance organization or pharmacy benefit manager, furnish the cost, benefit, and coverage data required by this subdivision to the subscriber, the subscriber's health care provider, or the authorized third party and shall ensure that such data is: (i) current no later than one business day after any change to the cost, benefit, or coverage data is made; (ii) provided through a RTBT when the request is made by the subscriber's health care provider; and (iii) in a format that is easily accessible to the requestor.

(d) When providing the data required by paragraph (c) of this subdivision, the health maintenance organization or pharmacy benefit manager shall use established industry content and transport standards published by:

(i) a standards developing organization accredited by the American National Standards Institute (ANSI), including, the National Council for Prescription Drug Programs (NCPDP), ASC X12, Health Level 7; or

(ii) a relevant federal or state governing body, including the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology.

(iii) another format deemed acceptable to the department which provides the data prescribed in paragraph (c) of this subdivision and in the same timeliness as required by this section.

(e) A facsimile shall not be considered an acceptable electronic format pursuant to this subdivision.

(f) Upon a request made pursuant to paragraph (c) of this subdivision, the health maintenance organization or pharmacy benefit manager shall provide the following data for any drug covered under the subscriber's subscriber contract:

(i) subscriber-specific eligibility information;

(ii) subscriber-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage, and cost-sharing data for the prescribed drug and clinically-appropriate alternatives, when appropriate;

(iii) subscriber-specific cost-sharing information that describes variance in cost-sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the insured's benefit; and

(iv) applicable utilization management requirements.

(g) A health maintenance organization or pharmacy benefit manager

shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term. A health maintenance organization or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

(h) A health maintenance organization and pharmacy benefit manager shall not, except as may be required or authorized by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required; nor shall a health maintenance organization or pharmacy benefit manager penalize a health care provider for disclosing such information to a subscriber or legally prescribing, administering, or ordering a lower cost, clinically appropriate alternative.

(i) Nothing in this subdivision shall be construed to limit access to the most up-to-date subscriber-specific eligibility or subscriber-specific prescription cost and benefit data by the health maintenance organization or pharmacy benefit manager.

(j) Nothing in this subdivision shall interfere with subscriber choice and a health care provider's ability to convey the full range of prescription drug cost options to a subscriber. Health maintenance organizations and pharmacy benefit managers shall not restrict a health care provider from communicating to the subscriber prescription cost options.

* NB There are 2 sb 8's

*** § 4408-a. Integrated delivery systems.** 1. Legislative purpose and findings. The legislature intends to facilitate the ability of integrated delivery systems to assume a larger role in delivering a full array of health care services, from primary and preventive care through acute inpatient hospital and post-hospital care to a defined population for a determined price. The legislature finds that the formation and operation of integrated delivery systems under this section will promote the purposes of federal and state anti-referral statutes which are to reduce over-utilization and expenditures and finds that such statutes should not be interpreted to interfere with the development of such integrated delivery systems or impose liability for arrangements between an integrated delivery system certified pursuant to this section and its

participating providers and entities. The legislature further finds that the development of integrated delivery systems will reduce costs and enhance quality. It intends that systems acting pursuant to a certificate of authority issued under this section shall not be subject to state or federal antitrust liability for doing so.

2. Definitions. For the purposes of this section:

(a) "Applicant" means a separate legal entity created for the purpose of establishing and operating an integrated delivery system. Such entity shall be composed of or controlled by one or more affiliated providers or one or more affiliated groups of providers.

(b) "Provider" means an entity licensed or certified under article twenty-eight or thirty-six of this chapter; an entity licensed or certified under article sixteen, twenty-three, thirty-one or thirty-two of the mental hygiene law; or a health care practitioner, or combination of health care practitioners, licensed under title eight of the education law. Every provider shall be: (i) a natural person; (ii) a partnership all of whose members are natural persons and that is not a limited partnership; or (iii) a corporation none of whose stock is owned by another corporation.

3. The commissioner, after receiving from the superintendent of financial services the evaluations and approvals required pursuant to subdivision seven of this section, may issue a certificate of authority to an applicant which satisfies the conditions under this section for issuance established by the commissioner and which seeks to deliver comprehensive health services, on a capitated basis, including inpatient services, to:

(a) persons who are receiving benefits under title XVIII of the federal social security act; or

(b) persons who are receiving benefits under title XIX of the federal social security act and commercial enrollees; or

(c) an enrollee population which includes persons receiving benefits under titles XVIII and XIX of the federal social security act and commercial enrollees.

4. An applicant must demonstrate to the commissioner that it will

provide at least seventy-five percent of the total expenditures for covered health care items and services directly to its enrollees through the provider, affiliated providers or affiliated groups of providers comprising such applicant. The applicant shall make arrangements or referrals for any covered health care items and services not provided directly to its enrollees by such applicant.

5. A provider shall be deemed affiliated with another provider or group of providers if, through contract, ownership or otherwise:

(a) one provider, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than fifty-one percent of the voting rights or governance rights of another;

(b) each provider is a participant in a lawful combination under which each provider shares, either directly or indirectly, substantial financial risk in connection with the activities and services of such combination; or

(c) a provider is a corporate member of a provider organized as a not-for-profit corporation duly designated pursuant to section six hundred one of the not-for-profit corporation law.

6. The commissioner shall be responsible for evaluating, approving and regulating all matters relating to delivery systems, quality of care and access to care to be provided through the integrated delivery system. In performing this responsibility, the commissioner shall assure:

(a) that the formation and operation of the integrated delivery system will enhance access to health services in the area to be served; and

(b) subject to subdivision four of this section, the comprehensive health services will be provided by the applicant through its proposed delivery system (including through providers other than those composing, affiliated with or controlling the applicant).

7. (a) The superintendent of financial services, in consultation with the commissioner in accordance with a protocol to be specified in a memorandum of understanding between the commissioner and the superintendent of financial services regarding fiscal solvency, shall be responsible for evaluating, approving and regulating all matters relating to premium rates, subscriber contracts and fiscal solvency,

including reserves, surplus and provider contracts to the extent such contracts relate to fiscal solvency matters. The superintendent of financial services, in the administration of this subdivision, shall:

- (i) be guided by the standards which govern the fiscal solvency of a health maintenance organization, provided, however, that the superintendent of financial services shall recognize and consider the specific delivery components, operational capacity and financial capability of the applicant for a certificate of authority; and

- (ii) not apply financial solvency standards that exceed those required for a health maintenance organization.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of the subscribers to integrated delivery systems. The superintendent of financial services must be satisfied that the applicant is fiscally sound, and has made adequate provisions to pay for services:

- (i) that are furnished by providers that are not affiliated with the applicant;

- (ii) to meet the specialized health care needs of certain enrollees needing care at specialty care centers; and

- (iii) for which claims are submitted after the period for which the applicant will receive payments.

8. The integrated delivery system shall have its premiums determined on a community-rated basis in accordance with the insurance law except where the enrollees are eligible to receive services under title XIX of the federal social security act in which case the premium rates shall be established by the commissioner, in consultation with the superintendent of financial services, subject to the approval of the director of the division of the budget.

9. An integrated delivery system shall be subject to the provisions of the insurance law that are applicable to health maintenance organizations, this chapter and regulations applicable to health maintenance organization, and any regulations promulgated by the commissioner or superintendent of financial services to implement this section. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of

the insurance law, the provisions of this section shall prevail.

10. No certificate of authority for an integrated delivery system shall be issued pursuant to this section on or after April first, two thousand two and integrated delivery systems issued certificates before such date shall accept no new enrollees thereafter.

* NB There are 2 § 4408-a's

*** § 4408-a. Grievance procedure.** 1. A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article, and any other organization certified pursuant to this article shall establish and maintain a grievance procedure. Pursuant to such procedure, enrollees shall be entitled to seek a review of determinations by the organization other than determinations subject to the provisions of article forty-nine of this chapter.

2. (a) An organization shall provide to all enrollees written notice of the grievance procedure in the member handbook and at any time that the organization denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an organization denies a service as an adverse determination as defined in article forty-nine of this chapter, the organization shall inform the enrollee or the enrollee's designee of the appeal rights provided for in article forty-nine of this chapter.

(b) The notice to an enrollee describing the grievance process shall explain: (i) the process for filing a grievance with the organization; (ii) the timeframes within which a grievance determination must be made; (iii) the right of an enrollee to designate a representative to file a grievance on behalf of the enrollee; and (iv) notice of the name, address, phone number and website of the department designated consumer assistance program and the independent substance use disorder and mental health ombudsman established by section 33.27 of the mental hygiene law within notices of adverse grievances and appeals determinations.

(c) The organization shall assure that the grievance procedure is reasonably accessible to those who do not speak English.

3. (a) The organization may require an enrollee to file a grievance in writing, by letter or by a grievance form which shall be made available by the organization and which shall conform to applicable standards for readability.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, an enrollee may submit an oral grievance in connection with: (i) a denial of, or failure to pay for, a referral; or (ii) a determination as to whether a benefit is covered pursuant to the terms of the enrollee's contract. In connection with the submission of an oral grievance, an organization may require that the enrollee sign a written acknowledgment of the grievance prepared by the organization summarizing the nature of the grievance. Such acknowledgment shall be mailed promptly to the enrollee, who shall sign and return the acknowledgment, with any amendments, in order to initiate the grievance. The grievance acknowledgment shall prominently state that the enrollee must sign and return the acknowledgment to initiate the grievance. If an organization does not require such a signed acknowledgment, an oral grievance shall be initiated at the time of the telephone call.

(c) Upon receipt of a grievance, the organization shall provide notice specifying what information must be provided to the organization in order to render a decision on the grievance.

(d) (1) An organization shall designate personnel to accept the filing of an enrollee's grievance by toll-free telephone no less than forty hours per week during normal business hours and, shall have a telephone system available to take calls during other than normal business hours and shall respond to all such calls no less than the next business day after the call was recorded.

(2) Notwithstanding the provisions of subparagraph one of this paragraph, an organization may, in the alternative, designate personnel to accept the filing of an enrollee's grievance by toll-free telephone not less than forty hours per week during normal business hours and, in the case of grievances subject to subparagraph (i) of subdivision four of this section, on a twenty-four hour a day, seven day a week basis.

4. Within fifteen business days of receipt of the grievance, the organization shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the organization to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than: (i) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; (ii) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and (iii) forty-five days after the receipt of all necessary information in all other instances.

5. The organization shall designate one or more qualified personnel to review the grievance; provided further, that when the grievance pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals.

6. The notice of a determination of the grievance shall be made in writing to the enrollee or to the enrollee's designee. In the case of a determination made in conformance with subparagraph (i) of subdivision four of this section, notice shall be made by telephone directly to the enrollee with written notice to follow within three business days.

7. The notice of a determination shall include: (i) the detailed reasons for the determination; (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination; (iii) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal; and (iv) notice of the name, address, phone number and website of the department designated consumer assistance program and the independent substance use disorder and mental health ombudsman established by section 33.27 of the mental hygiene law within notices of adverse grievances and appeals determinations.

8. An enrollee or an enrollee's designee shall have not less than sixty business days after receipt of notice of the grievance

determination to file a written appeal, which may be submitted by letter or by a form supplied by the organization.

9. Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the organization to respond to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

10. The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

11. The organization shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:

(i) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health; and

(ii) thirty business days after the receipt of all necessary information in all other instances.

12. The notice of a determination on an appeal shall include: (i) the detailed reasons for the determination; and (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination.

13. An organization shall not retaliate or take any discriminatory action against an enrollee because an enrollee has filed a grievance or appeal.

14. An organization shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the enrollee's acknowledgment of the grievance, if any; the determination made by the organization including the date of the determination and the titles and, in the case of a clinical determination, the credentials of the organization's personnel who reviewed the grievance. If an enrollee files an appeal of the grievance, the file shall include the date and a copy of the enrollee's appeal, the determination made by the organization including the date of the determination and the titles and, in the case of clinical determinations, the credentials, of the organization's personnel who reviewed the appeal.

15. An organization shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of a preference to receive such notification by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. The organization shall retain documentation of preferred notification methods and present such records to the commissioner upon request.

16. The rights and remedies conferred in this article upon enrollees shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.

* NB There are 2 § 4408-a's

§ 4409. Health maintenance organizations; examinations. 1. In order to carry out the provisions of this article, the commissioner, pursuant to his authority under section two hundred six of this chapter, shall examine not less than once every three years, each health maintenance

organization and all participating entities through which such health maintenance organization offers health services as to the quality of health care services offered, and the adequacy of its provider arrangements.

2. (a) The superintendent shall examine not less than once every three years into the financial affairs of each health maintenance organization, and transmit his findings to the commissioner. In connection with any such examination, the superintendent shall have convenient access at all reasonable hours to all books, records, files and other documents relating to the affairs of such organization, which are relevant to the examination. The superintendent may exercise the powers set forth in sections three hundred six and three hundred ten of the insurance law in connection with such examinations, and may also require special reports from such health maintenance organizations as specified in section three hundred eight of the insurance law. As part of an examination, the superintendent shall review determinations of coverage for substance use disorder treatment and shall ensure that such determinations are issued in compliance with section four thousand three hundred three of the insurance law and title one of article forty-nine of this chapter.

(b) The department is authorized to address to any health maintenance organization, and managed long term care plan with a certificate of authority pursuant to section forty-four hundred three-f of this article, or officers thereof, any inquiry in relation to its contracts with providers and other entities providing covered services to the health maintenance organization's or managed long term care plan's enrollees, including but not limited to the rates of payment and payment terms and conditions therein. Every entity or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the department, signed by such individual, or by such officer or officers of a corporation, as the department shall designate, and affirmed by them as true under penalty of perjury. Failure to comply with the requirements of this section shall be subject to civil penalties under section twelve of this chapter. Each day after the deadline established by the department for reply until such time that the provider submits a good faith response shall be considered a

separate and subsequent violation. In accordance with the process outlined in this paragraph, employers shall provide any documents or materials in the employer's possession, custody, or control that are requested by the department as needed to support or verify the employer's reply.

(c) Any report, information, documents, or other materials furnished to the department under this subdivision shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner, including article six of the public officers law or department regulations in conformance therewith, except as provided in this section, pursuant to a judicial subpoena issued in a pending action or proceeding, or upon formal written request by the department of labor, the office of attorney general, or a duly authorized public agency.

(d) The department shall no less than annually provide a report to the governor, temporary president of the senate, and speaker of the assembly summarizing the information obtained by the department under paragraph (b) of this subdivision. Such report shall not contain individually identifiable data.

3. The superintendent and the commissioner are authorized to share and exchange information obtained by them in the exercise of their respective responsibilities under the insurance law and this chapter.

4. Nothing contained in this section shall be deemed to require the public disclosure of privileged patient information.

§ 4410. Health maintenance organizations; professional services. 1. The provision of comprehensive health services directly or indirectly, by a health maintenance organization through its comprehensive health services plan shall not be considered the practice of the profession of medicine by such organization or plan. However, each member, employee or agent of such organization or plan shall be fully and personally liable and accountable for any negligent or wrongful act or misconduct committed by him or any person under his direct supervision and control while rendering professional services on behalf of such organization or

plan.

2. Unless the patient waives the right of confidentiality, a health maintenance organization or its comprehensive health services plan shall not be allowed to disclose any information which was acquired by such organization or plan in the course of the rendering to a patient of professional services by a person authorized to practice medicine, registered professional nursing, licensed practical nursing, or dentistry, and which was necessary to acquire to enable such person to act in that capacity, except as may be otherwise required by law. A non-participating provider shall provide an enrollee's organization with such patient information as is reasonably required by the organization to administer its plan. In making such disclosure a provider shall comply with the provisions of subdivision six of section eighteen of this chapter concerning the disclosure of patient information to third parties provided, however, that with respect to a protected individual as defined in subdivision six of section twenty-seven hundred eighty of this chapter, disclosure shall be made only pursuant to an enrollee's written authorization and shall otherwise be consistent with the requirements of such section and rules and regulations promulgated pursuant thereto.

3. Notwithstanding the provisions of this section, the provisions of section four hundred twenty-two of the social services law shall apply to any information or reports submitted by a health maintenance organization to the statewide central register of child abuse and maltreatment reports.

4. (a) The commissioner shall have access to patient-specific medical information, including encounter data, maintained by a health maintenance organization or other organization certified pursuant to this article for the purposes of quality assurance and oversight, subject to any other limitations of federal and state law regarding disclosure thereof to third parties and subject to the provisions of this subdivision. The provisions of sections thirty-one hundred one, and forty-five hundred four, forty-five hundred seven and forty-five hundred eight of the civil practice law and rules, subdivision three of this

section and section 33.13 of the mental hygiene law, shall not bar disclosure by the health maintenance organization to the commissioner for such purposes.

(b) The commissioner may only obtain enrollee information subject to the establishment of protocols that will ensure that such patient-specific information is not disclosed to third parties other than to entities serving as agents of the state for the purposes of quality assurance and oversight. Such protocols shall be developed in consultation with representatives of health maintenance organizations, health care provider organizations and consumer organizations and shall, where possible, include the development of a unique confidential identifier to be used in connection with patient-specific data. These protocols shall address issues relating to the collection, maintenance, and disclosure of such patient-specific information. Such protocols shall be promulgated as regulations, provided however, that protocols or regulations in use prior to the effective date of this subdivision shall remain in effect until the regulations developed hereunder are promulgated.

(c) In addition to any other sanction or penalty as provided by law, any employee of the department who willfully violates this regulation or any other rule or procedure pertaining to the disclosure of any material collected pursuant to this subdivision shall be deemed to have committed an act of misconduct and shall be disciplined in accordance with the provisions of the civil service law.

§ 4411. Construction. The provisions of laws other than this article shall not be applicable to the certification of any health maintenance organization under this article except where so specified; provided, however, that no health maintenance organization shall include in its name the words "insurer", "casualty", "health and accident" or any words generally regarded as descriptive of the insurance function; provided further, that this provision shall not be construed as prohibiting the participation in a comprehensive health services plan of any corporation or other entity organized under any other law, to the extent that such corporations or entities are authorized to participate by law, including but not limited to the insurance law, business corporation law,

education law, not-for-profit corporation law, or general municipal law; nor shall this section be considered to prevent the application of any other law to the entities comprising such plan.

§ 4412. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

§ 4413. Savings clause. Nothing contained in this article or any act amendatory thereof shall affect or impair the validity of any act done or right accruing, accrued or acquired or any order, judgment, or status established prior to the enactment of this article or prior to the amendment of any act amendatory thereof.

Medical corporations organized pursuant to the provisions of former article forty-four of the public health law in effect prior to the effectiveness of the provisions of this article may continue to operate pursuant to the provisions of law in effect prior to the effectiveness hereof.

Health maintenance organizations that applied for a license under article forty-three of the insurance law and receive approval under article twenty-eight of the public health law may continue under the provisions of the laws in existence on the effective date of this article.

§ 4414. Health care compliance programs. 1. The commissioner, after consultation with the superintendent of financial services, shall by regulation establish standards and criteria for compliance programs to be implemented by persons providing coverage or coverage and service

pursuant to any public or governmentally-sponsored or supported plan for health care coverage or services. Such regulations shall include provisions for the design and implementation of programs or processes to prevent, detect and address instances of fraud and abuse. Such regulations shall take into account the nature of the entity's business and the size of its enrolled population. The commissioner and the superintendent of financial services shall accept programs and processes implemented pursuant to section four hundred nine of the insurance law as satisfying the obligations of this section and the regulations promulgated thereunder when such programs and processes incorporate the objectives contemplated by this section.

2. Notwithstanding any provisions of section twelve of this chapter to the contrary, penalties collected from any health maintenance organization certified pursuant to this article resulting from a violation of the health maintenance organization's mental health and substance use disorder parity compliance program shall be deposited into the behavioral health parity compliance fund as established pursuant to section ninety-nine-hh of the state finance law.

*** § 4416. Excess reserves of certain health maintenance organizations.**

1. The commissioner is authorized to require any comprehensive health services plan issued a special purpose certificate of authority under section forty-four hundred three-a of this article, that satisfies the definition of corporation in subparagraph five of paragraph (a) of section one hundred two of the not-for-profit corporation law or is exempt from taxation under section 501 of the Internal Revenue Code of 1986 to submit all financial and other books and records the commissioner deems necessary in order to evaluate an organization's reserves. The commissioner, in consultation with the superintendent of the department of financial services, shall examine such books and records and shall issue a report on the health maintenance organization's reserves. A request under this section may be made no more than two times per year per plan.

2. Except for any public benefit corporation, the commissioner is

authorized to promulgate regulations establishing a presumptive reserve ceiling for any comprehensive health services plan issued a special purpose certificate of authority under section forty-four hundred three-a of this article that satisfies the definition of corporation in subparagraph five of paragraph (a) of section one hundred two of the not-for-profit corporation law or that is exempt from taxation under section 501 of the Internal Revenue Code of 1986. Such regulations shall express the presumptive reserve ceiling as a percentage of the minimum contingent reserves applicable to such health maintenance organizations. The presumptive reserve ceiling shall be no less than one hundred fifty percent of the minimum contingent reserves applicable to such plans. In the event that the commissioner determines that a plan subject to this subdivision has reserves in excess of the presumptive reserve ceiling for two consecutive quarters, the commissioner may make a preliminary determination that all or a portion of such reserves in excess of the ceiling should be redeployed by depositing such excess reserves in the health care transformation fund pursuant to subdivision three of this section. Prior to making a preliminary determination, the commissioner shall consider whether such redeployment is consistent with financial soundness and efficiency and to the extent to which such reserves are being maintained consistent with the programmatic goals of the state. Upon making such a preliminary determination, the department shall notify the plan and the plan shall be afforded an opportunity to submit information to the department to justify why such reserves in excess of the ceiling are necessary and should not be so redeployed. Provided however, under no circumstances shall the redeployment of such reserves for any plan exceed seven hundred and fifty million dollars annually.

3. If, after considering the information submitted by the plan, the commissioner adheres to the preliminary determination that the reserves in excess of the ceiling should be redeployed, the commissioner shall direct that such reserves be deposited to the health care transformation fund established pursuant to section ninety-two-hh of the state finance law or its successor to be used for investment in the transformation of health care delivery, including for capital investment, debt retirement or restructuring, housing and other social determinants of health, or transitional operating support to health care providers, pursuant to a

plan prepared by the commissioner and approved by the director of the division of the budget.

4. Notwithstanding any law to the contrary, on or after August first, two thousand eighteen no entity subject to subdivision two of this section shall transfer or loan any funds to any subsidiary or member of the entity's holding company system or to a member or stockholder where a purpose of the transfer or loan is to avoid the application of this section.

* NB Repealed August 1, 2027

ARTICLE 45

MEDICAL REFERRAL SERVICES

Section 4500. Legislative findings and statement of policy.

4501. Medical referral service businesses prohibited.

4502. Penalties.

4503. Application.

§ 4500. Legislative findings and statement of policy. The security of the health and welfare of the residents of this state requires, that the utmost attention be given to assure that persons seeking medical care and treatment in this state receive adequate care rendered within the standards of ethics and public policy applicable to all practices of medicine. Medical referral services, organized as profit making enterprises within this state, have been found to be engaged in the practice of medicine, have been sharing fees received for referrals with doctors and hospitals to whom patients are referred, have been otherwise compensating doctors and hospitals for accepting patients referred to them, have been giving medical advice by telephone to persons seeking referrals and have been advertising their services, all in violation of the standards of ethics and public policy applicable to the practice of medicine and which would be violations of standards of professional conduct if the acts were performed by physicians. Such profit making referral services have consistently engaged in practices inimical to the public interest which would be prohibited to physicians and have engaged

in relationships with physicians which are in violation of the laws and public policy of this state and which have permitted physicians to benefit indirectly from acts and practices which would be prohibited to them directly. It is hereby declared to be the public policy of this state that the public health, safety and welfare of the citizens of this state require that such profit making medical referral service organizations be declared to be invalid and unlawful in this state.

§ 4501. Medical referral service businesses prohibited. 1. No person, firm, partnership, association or corporation, or agent or employee thereof, shall engage in for profit any business or service which in whole or in part includes the referral or recommendation of persons to a physician, dentist, hospital, health related facility, or dispensary for any form of medical or dental care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation shall create a presumption that the business or service is engaged in for profit.

2. No physician, dentist, hospital, health related facility or dispensary shall enter into a contract or other form of agreement to accept for medical or dental care or treatment any person referred or recommended for such care or treatment by a medical or dental referral service business located in or doing business in another state if the medical or dental referral service business would be prohibited under this section if the business were located in or doing business in this state.

§ 4502. Penalties. 1. A violation of the provisions of this section shall constitute a misdemeanor and upon conviction thereof may be punished by imprisonment for not longer than one year or a fine of not more than five thousand dollars or by both such fine and imprisonment.

2. Whenever there shall be a violation of this section, an application also may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction to issue

an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violation; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding the court may make allowances to the attorney general as provided in section 8303, subdivision 6 of the civil practice law and rules. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

§ 4503. Application. The provisions of this article shall not apply to any individual, agency, association or corporation not organized or incorporated for pecuniary profit or financial gain or to any organization or association which is exempt from taxation pursuant to section 501 (c) of title 26 of the United States Code, constituting the Internal Revenue Code of 1954, as amended.

ARTICLE 45-A

DISCLOSURE OF MATERIAL TRANSACTIONS

Section 4550. Definitions.

4551. Disclosure of material transactions.

4552. Notice of material transactions; requirements.

§ 4550. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management, administrative functions, and policies of a health care entity, whether through the ownership of voting securities or rights, control, either directly or indirectly, by contract (except a commercial contract for goods or

non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of being an officer or director of a health care entity. "Control" shall be presumed to exist if any person directly or indirectly owns, controls, or holds with the power to vote ten percent or more of the voting securities of a health care entity.

2. "Health care entity" shall include but not be limited to a physician practice, group, or management services organization or similar entity providing all or substantially all of the administrative or management services under contract with one or more physician practices, provider-sponsored organization, health insurance plan, or any other kind of health care facility, organization or plan providing health care services in this state; provided, however, that a "health care entity" shall not include an insurer authorized to do business in this state, or a pharmacy benefit manager registered or licensed in this state. An "insurer" shall not include non-insurance subsidiaries and affiliated entities of insurance companies regulated under the insurance law or this chapter.

3. "Health equity" shall mean achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socioeconomic disadvantages, and systemic disadvantages.

4. "Material transaction" shall mean:

(a) any of the following, occurring during a single transaction or in a series of related transactions that take place within a rolling twelve month time period, and meet or exceed thresholds, for factors including but not limited to changes in revenue:

(i) a merger with a health care entity;

(ii) an acquisition of one or more health care entities, including but not limited to the assignment, sale, or other conveyance of assets, voting securities, membership, or partnership interest or the transfer of control;

(iii) an affiliation agreement or contract formed between a health

care entity and another person; or

(iv) the formation of a partnership, joint venture, accountable care organization, parent organization, or management services organization for the purpose of administering contracts with health plans, third-party administrators, pharmacy benefit managers, or health care providers as prescribed by the commissioner by regulation.

(b) "Material transaction" shall not include a clinical affiliation of health care entities formed for the purpose of collaborating on clinical trials or graduate medical education programs and shall not include any transaction that is already subject to review under article twenty-eight, thirty, thirty-six, forty, forty-four, forty-six, forty-six-A, or forty-six-B of this chapter. "Material transaction" shall not include a de minimis transaction, which shall mean for purposes of this article a transaction or a series of related transactions which result in a health care entity increasing its total gross in-state revenues by less than twenty-five million dollars.

§ 4551. Disclosure of material transactions. Pursuant to this article, the department shall adopt a process for the disclosure and notice of material transactions. The items disclosed shall include the factors listed in this article. Nothing in this article shall limit or restrict the authority of the superintendent of financial services under article fifteen, sixteen, seventeen, forty-two, forty-three, seventy-one, or seventy-three of the insurance law, or regulations promulgated thereunder.

§ 4552. Notice of material transactions; requirements. 1. A health care entity shall submit to the department written notice, with supporting documentation as described below and further defined in regulation developed by the department, which the department shall be in receipt of at least thirty days before the closing date of the transaction, in the form and manner prescribed by the department. Immediately upon the submission to the department, the department shall submit electronic copies of such notice with supporting documentation to the antitrust, health care and charities bureaus of the office of the

New York attorney general. Such written notice shall include, but not be limited to:

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

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

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

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

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

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

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

(ii) any commitments by the health care entity to address anticipated impacts.

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

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

(i) a summary of the proposed transaction;

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

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

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

3. A health care entity that is a party to a material transaction shall notify the department upon closing of the transaction in the form

and manner prescribed by the department.

4. Failure to notify the department of a material transaction under this section shall be subject to civil penalties under section twelve of this chapter. Each day in which the violation continues shall constitute a separate violation.

ARTICLE 46

CONTINUING CARE RETIREMENT COMMUNITIES

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§ 4600. Legislative findings and purpose. The dramatic increase in the numbers of elderly people, especially those seventy-five years of age and older, coupled with the special housing and health care needs of this growing segment of the population, requires the development of new and creative approaches to help ensure the care of older people in residential settings of their own choice. If carefully planned and monitored, life care communities have the potential to provide a continuum of care for older people that will provide an attractive residential option for such persons, while meeting their long term care needs for life. To ensure that the financial, consumer, and health care interest of individuals who enroll in such communities will be protected, such communities must be effectively managed and carefully overseen.

The intent of the legislature, therefore, is to allow for the prudent development of life care communities. The legislature further intends to require that the relevant state agencies coordinate the regulation of such communities in order to ensure that there are adequate safeguards for those elderly who become residents and to assist in the orderly development, of such communities. Although lead responsibility for the interagency coordination of the regulation and establishment of such

communities is vested in the department of health, the legislature does not intend that such communities become or be perceived as primarily medically-oriented facilities. The legislature intends, instead, that such communities be viewed as an attractive and innovative residential alternative for older New Yorkers who are seeking to maintain, to the extent possible, an independent and active life in a community in which their long-term care needs will be met.

§ 4601. Definitions. As used in this article:

1. "Certificates" or "certificate of authority" shall mean an authorization in writing, approved by the council and issued by the commissioner, for an operator to operate a continuing care retirement community and to enter into continuing care retirement contracts and continuing care at home contracts pertaining to such community.

2. "Commissioner" shall mean the commissioner of health.

2-a. "Continuing care retirement contract" or "continuing care at home contract" shall mean a single contract to provide a person the services provided by a continuing care retirement community.

2-b. "Continuing care retirement community" or "community" shall mean a facility or facilities established to provide a comprehensive, cohesive living arrangement for the elderly, oriented to the enhancement of the quality of life and which, pursuant to a contract, at a minimum:

a. for continuing care retirement contracts, provides independent living units, and meal plan options. The independent living unit can be made available either through a non-equity arrangement or through an equity arrangement including, but not limited to a cooperative or condominium. For purposes of this article, the purchase price of an independent living unit in an equity arrangement, regardless of the form of the purchase agreement, shall not be considered an entry fee for purposes of calculating reserve liabilities, but shall be considered an entry fee for escrow purposes;

b. provides a range of health care and social services, subject to such terms as may be included within the contract, which shall include adult care facility services of an on-site or affiliated adult care facility, and at a minimum, sixty days of prepaid services of an on-site or affiliated nursing facility for residents not receiving services under a fee-for-service contract;

c. provides access to health services as defined in the contract, prescription drugs, and rehabilitation services;

d. nothing in this article shall eliminate the obligation of a continuing care retirement community to provide at least sixty days of prepaid nursing facility services to all residents, with the exception of residents receiving services under the terms of a fee-for-service continuing care contract as defined in this section. The prepaid days must include the first sixty days of nursing facility services, whether or not consecutive, not covered by Title XVIII of the federal social security act;

e. communities established under this article and offering fee-for-service continuing care contracts must offer, along with such fee-for-service continuing care contracts, life care and/or continuing care contracts as defined in subdivision eight-a of this section; and

f. communities established under this article offering continuing care at home contracts must also offer continuing care retirement contracts and must maintain a continuing care retirement community that operates in support of the continuing care at home contracts.

3. "Contracts" or "agreements" shall mean continuing care at home or continuing care retirement contracts as defined in this article.

4. "Control", "controlling", "controlled by", and "under common control with" shall mean the possession, directly, or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities or voting

rights, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of his being an officer or director of such other person. Control shall be presumed to exist if any person directly or indirectly owns, controls, or holds with the power to vote ten percent or more of the voting securities or voting rights of any other person or is a corporate member of the legal entity.

5. "Council" shall mean the continuing care retirement community council, established pursuant to section forty-six hundred two of this article.

6. "Entrance fee" shall mean an initial or deferred transfer to an operator of a sum of money, made or promised to be made by a person or persons entering into a continuing care retirement contract or continuing care at home contract, for the purpose of ensuring services pursuant to such a contract.

7. "Facility" shall mean any place in which an operator undertakes to provide a resident with the services of a continuing care retirement community, pursuant to a contract, whether such place is constructed, owned, leased, rented, or otherwise contracted for by the operator.

8. "Life care contract" shall mean a single continuing care retirement contract or a continuing care at home contract to provide a person, for the duration of such person's life, the services provided by the continuing care retirement community, which services shall include unlimited services of the affiliated community's nursing facility or affiliated nursing home. Such term also shall mean a single continuing care retirement contract to provide a person, for the duration of such person's life, the services provided by the continuing care retirement community under an arrangement in which the costs of the residents' unlimited nursing home or home care services are paid for in whole or in part by a long term care insurance policy approved by the superintendent in accordance with applicable regulations or by long term care insurance or medical assistance payments in accordance with the partnership for long term care program pursuant to the provisions of section three

hundred sixty-seven-f of the social services law, section three thousand two hundred twenty-nine of the insurance law and section four thousand six hundred twenty-three of this chapter.

8-a. "Fee-for-service continuing care contract" shall mean a single continuing care retirement contract that provides long-term and other services on a per diem, fee-for-service or monthly rate.

8-b. "Continuing care at home contract" shall mean a single contract to provide a person with long term care services and supports based upon the person's needs and coordinated by a case manager, which shall include services provided to the person in his or her residence and services of the community's nursing facility and adult care facility, or affiliated facilities.

9. "Life care shall mean those services provided pursuant to a "life care contract".

10. "Living unit" shall mean an apartment, room, cottage, or other area within a community set aside for the exclusive use of one or more residents, or in the case of a continuing care at home contract, the contract holder's private residence.

11. "Monthly care fee" shall mean the monthly cost to a resident for prepayment of any services, including rent, rendered pursuant to a contract, exclusive of entrance fees or other prepayments, and any other regular periodic charges to the resident, determined on a monthly basis, pursuant to the provisions of a contract.

12. "Operator" shall mean a legal entity operating a continuing care retirement community pursuant to a certificate of authority.

13. "Priority reservation agreement" shall mean a cancelable agreement between a prospective continuing care retirement community applicant, an applicant for a certificate of authority or an operator and a prospective resident, for the purpose of evaluating market demand for a proposed continuing care retirement community and for the purpose of

guaranteeing to prospective residents an opportunity for priority placement in a continuing care retirement community, under which the prospective resident will pay a refundable priority reservation fee. A priority reservation agreement does not fall within the meaning of contracts or agreements as defined in subdivision three of this section.

14. "Priority reservation fee" shall mean the refundable sum of money paid by a prospective resident for deposit with the escrow agent for a prospective continuing care retirement community applicant, an applicant for a certificate of authority or an operator pursuant to a priority reservation agreement.

15. "Resident" shall mean any person who, pursuant to a continuing care retirement contract or continuing care at home contract, is entitled to reside in and/or receive services from a continuing care retirement community.

15-a. "ILU resident" shall mean a continuing care retirement contract holder who resides in a living unit within the continuing care retirement community.

15-b. "Home resident" shall mean a continuing care at home contract holder who resides in a private residence off of the continuing care retirement community campus.

16. "Residential health care demonstration facility" shall mean a residential health care facility containing up to sixty beds, within the defined geographical boundary of each health systems agency established under the provisions of subdivision (c) of section twenty-nine hundred four of this chapter, provided that such residential health care facility is an integrated part of a comprehensive system of residential and support services for the elderly, providing either directly or through one or more affiliated entities, prior to the effective date of this subdivision, on or adjacent to the site of the proposed residential health care facility, independent living units, an adult care facility as defined in section two of the social services law and a range of health care and social services, which may include home health care,

counselling, case management and information and referral.

16-a. "Social services" shall mean those services which may include, but not be limited to counseling, case management, and information and referral.

17. "Superintendent" shall mean the superintendent of financial services.

§ 4602. Commissioner; powers and duties. The commissioner shall have the following powers and duties:

1. to receive applications from potential operators of continuing care retirement communities and to distribute such applications for review to the participating agencies;

2. to develop uniform forms for applications for certificates of authority, to review the status of such applications, and to coordinate the review of such applications in order to minimize duplication or delay;

3. to provide information to entities wishing to establish continuing care retirement communities and to persons interested in becoming residents of such communities, to the extent appropriate, with concerns relating to the operation of such facilities;

4. to issue certificates of authority to approved applicants;

5. to approve or reject applications to obtain a certificate of authority for the establishment and operation of a continuing care retirement community. In reviewing applications, the commissioner shall consider the extent to which the applications reflect various sponsorships, organizational structures, geographic dispersion, and the public benefit. In determining the public benefit of a community requiring construction of a total nursing facility component greater than or equal to ninety beds, the commissioner shall obtain and consider

the recommendation of the public health and health planning council with regard to the effect of the construction of the community's nursing facility beds upon existing facilities in the same geographic area;

6. to require the reporting of such facts and information as the commissioner may deem necessary to enforce the provisions of this article;

7. to coordinate the oversight of operating communities and to assign review and regulatory responsibility for particular aspects of such communities to the appropriate agencies, consistent with their legal authority, to assure consistent state supervision without duplication of inspection or regulatory review;

8. to make such recommendations to the governor and the legislature as may be necessary to encourage or further regulate the development of continuing care retirement communities;

9. to establish and charge equitable and reasonable annual charges for operators, not to exceed fifty dollars per approved living unit, to subsidize, in part, expenditures incurred in reviewing applications for certificates of authority and in inspecting, regulating, supervising and auditing continuing care retirement communities;

10. to adopt rules and regulations and amendments thereto to effectuate the provisions of this article;

11. to revoke, suspend, limit, or annul a certificate of authority under conditions set forth in section forty-six hundred fifteen of this article, including when such action is taken at the specific request of any participating council agency;

12. to carry out any other responsibilities entrusted to the commissioner pursuant to this chapter that may be necessary with regard to the health care activities of continuing care retirement communities;

13. to make available to all prospective operators all pertinent

regulations regarding health and insurance necessary to comply with this article;

14. to approve or reject applications for authorization by prospective continuing care retirement community applicants, entities that have filed an application for a certificate of authority and operators, to enter into cancellable priority reservation agreements and to collect refundable priority reservation fees from prospective residents;

15. to require the reporting of such facts and information as the commissioner may deem necessary to determine whether characteristics of residential health care demonstration facilities such as comprehensive systems of residential and support services for the elderly may be successfully incorporated into existing or approved continuing care retirement communities;

16. to review and approve or reject applications by continuing care retirement community operators to use entrance fees to assist the operator in financing the construction or purchase of a proposed continuing care retirement community in accordance with paragraph b of subdivision six of section forty-six hundred ten of this article;

17. to review and approve or reject any proposed financing by industrial development agencies of continuing care retirement communities pursuant to article eighteen-A of the general municipal law as authorized by section forty-six hundred four-a of this article; and

18. to coordinate the interagency regulatory review of the applications, development and operations of communities in order to minimize duplication or delay.

§ 4603. Continuing care retirement community council; powers and duties. 1. The continuing care retirement community council is hereby established, to consist of the following, or their designees: the attorney general; the commissioner; the director of the office for the aging; and eight public members appointed by the governor. Such public

members shall be representative of the public, and have a demonstrated expertise or interest in continuing care retirement communities; provided that no more than one such member shall be a sponsor, owner, operator, manager, member of a board of directors, or shareholder of a continuing care retirement community. At least two public members shall be residents of a continuing care retirement community. At least one of the public members shall be a representative of an organization with demonstrated experience in representing the interests of senior citizens. The public members of the council shall have fixed terms of four years. The council shall be chaired by the commissioner or the designee of such commissioner.

(a) Members of such council shall serve without compensation for their services as members of the council, except that each of them may be allowed the necessary and actual expenses which such member shall incur in the performance of their duties under this article.

(b) A majority of the appointed voting membership of the council shall constitute a quorum.

2. The council shall meet as often as the commissioner may deem necessary to fulfill its responsibilities. The council shall have the following powers and duties:

a. to advise the commissioner on policy matters related to the establishment and operation of continuing care retirement communities;

b. to advise the commissioner in the development of the state's overall policy regarding continuing care retirement communities and cause studies and research to be conducted as it may deem advisable and necessary; and

c. to make any other recommendations to the commissioner as may be necessary to encourage or further regulate the development of continuing care retirement communities.

§ 4603-a. Residential health care demonstration facilities. 1. The commissioner, upon approval of the continuing care retirement community

council and the public health council shall issue a certificate of incorporation of up to three residential health care demonstration facilities. Notwithstanding any provision of article twenty-eight of this chapter or any other provisions of law to the contrary, the public health council may approve without regard to the requirement of public need as set forth in subdivision three of section twenty-eight hundred one-a of this chapter, a certificate of incorporation or application for establishment of such facilities.

2. Not more than one hundred eighty residential health care demonstration facility beds shall be authorized and established in this state pursuant to this article.

3. In determining an application filed under article twenty-eight of this chapter, the public health council shall consider the number of elderly persons residing in and receiving services from each health systems agency established under the provisions of subdivision (c) of section twenty-nine hundred four of this chapter and such other information as the public health council may require to determine whether such system will promote the health and welfare of the elderly persons to whom it proposes to provide services.

4. An operating certificate issued pursuant to an application filed by a residential health care demonstration facility shall be conditioned upon an agreement by the operator of the facility to provide services only to persons who have been residents of the independent living units or adult care facility within the comprehensive system for at least thirty days prior to the admission of such person to the residential health care facility, unless the commissioner for good cause shown approves a waiver of such condition which may be effective only during the first twenty-four months after the issuance of the operating certificate.

5. The provisions of this article shall not apply to residential health care demonstration facilities, unless otherwise provided in this section or subdivision three of section forty-six hundred four of this article.

6. An application for approval pursuant to this section must be filed with the department on or before June thirtieth, nineteen hundred ninety-two.

7. Notwithstanding any other provision of this article, a residential health care facility heretofore established as a residential health care demonstration facility may hereafter provide services to persons who, for at least thirty days prior to the admission of such person to the residential health care facility, have been residents of any independent living unit or adult care facility operated by any not-for-profit corporation affiliated with such residential health care facility and located within the same county, provided that such residential health care facility becomes duly qualified to provide services to persons eligible for medical assistance under title eleven of article five of the social services law, and further provided that such residential health care facility remains an integrated part of a comprehensive system of residential and support services for the elderly as such system is described in this section and in subdivision sixteen of section forty-six hundred one of this article.

§ 4604. Certificate of authority required; application and approval.

1. No person shall construct, expand, acquire, maintain, or operate a continuing care retirement community, or enter into a contract as an operator, or solicit the execution of any contract for continuing care retirement community services to be provided within the state or advertise itself or otherwise hold itself as a "continuing care retirement community", without obtaining a certificate of authority pursuant to this article; provided, however, nothing in this subdivision shall prohibit a person, authorized pursuant to section forty-six hundred twenty-one or forty-six hundred twenty-two of this article, from entering into priority reservation agreements, soliciting, collecting or receiving priority reservation fees, or constructing and maintaining sales offices and model units with respect to a proposed continuing care retirement community.

2. In order to receive a certificate of authority to enter into contracts with respect to a particular community, a person or persons, hereinafter designated as the applicant, shall apply for a certificate of authority on forms prescribed by the commissioner and, in addition, shall submit the following:

a. a feasibility study, including a market analysis describing the characteristics of the population to be served;

b. an actuarial study;

c. an initial disclosure statement as provided pursuant to section forty-six hundred six of this title;

d. a copy of the proposed forms of contracts to be entered into with residents;

e. complete details of any agreements with a licensed insurer, including copies of proposed contracts, requiring the insurer to assume, wholly or in part, the cost of medical or health related services to be provided to a resident pursuant to a continuing care retirement contract or continuing care at home contract;

f. a copy of each of the basic organizational documents and agreements of the applicant of all participating entities;

g. a copy of the bylaws, rules and regulations and internal governing documents of the applicant;

h. architectural program and sketches for the community;

i. the proposed community plan, including the number of independent living units, skilled nursing facility beds, adult care facility beds, if any, and a description of other social and health services provided by the community;

j. copies of financial and personal disclosure information as required

by the council for the applicant and members of the board, officers, and controlling persons of the proposed continuing care retirement community, including:

(i) information necessary for the determination by the council of character, competence, and experience, where information adequate to make such determinations is not otherwise available to the council,

(ii) a list of continuing care retirement communities, adult care facilities and health care facilities owned or operated by the applicant, by any controlling persons of the applicant, or by entities with which the members of the applicant's board are affiliated; the address of each such facility; and the dates of ownership or operation of each such facility,

(iii) in the event that any such community or facility specified in this subdivision while under the control or operation of the applicant, or any controlling person has been subjected to a limitation, withdrawal, or refusal to grant accreditation by a recognized accreditation organization, because of failure to comply with standards governing the conduct and operation of the facility, information that describes the nature of the violation, the agency or body enforcing the standard (including its name and address), the steps taken by the facility to remedy the violation, and an indication of whether any accreditation has since been restored, and

(iv) a statement as to whether the applicant or any of its officers, directors, partners, managers or a principal, parent or subsidiary corporation:

(A) has been convicted of a crime or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgment if the criminal or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property,

(B) had a prior discharge in bankruptcy or was found insolvent in any court action,

(C) is or was subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, actions affecting a license to operate a hospital as defined by section twenty-eight hundred one of this chapter, or a facility required to be

licensed or certified by the department. The statement shall set forth the court or agency, date of conviction or judgment, the penalty imposed or damages assessed, or the date, nature and issuer of the order;

k. information which describes the populations to be served; and

l. any other information as may be required by regulations adopted pursuant to this article.

3. Nothing in this article shall be construed to enlarge, diminish or modify: a social services district's otherwise valid recovery under section three hundred sixty-nine of the social services law, nor medical assistance eligibility under title eleven of article five of the social services law nor applicable provisions of the estates, powers and trusts law. Except as otherwise provided in this article, the activities of continuing care retirement communities shall be subject to any other law governing such activities including but not limited to article twenty-eight of this chapter and article seven of the social services law and regulations promulgated thereunder; provided, however, that the provisions of paragraphs (d) and (e) of subdivision four of section twenty-eight hundred one-a and section twenty-eight hundred two of this chapter shall not apply, and provided that the provisions of paragraph (a) of subdivision one and the provisions of subdivision two of section four hundred sixty-one-b of the social services law with respect to public need and the provisions of subdivision one of section four hundred sixty-one-c of the social services law shall not apply to residents who have been admitted in accordance with a contract provided that, upon admission to the adult care facility, such residents shall be given a notice which shall include, at a minimum, information regarding facility services, resident responsibilities, supplemental services, resident rights and protections and circumstances that warrant transfer. The number of residential health care facility beds available pursuant to subdivision five of this section, without proof of public need therefor, shall be reduced by the number of residential health care demonstration facility beds that are approved pursuant to this article.

4. No certificate of authority shall be issued unless an application

meeting the requirements of this section and all other requirements established by law has been approved by:

a. (i) the superintendent of financial services as to the actuarial principles involved, the financial feasibility of the facility, the form and content of the proposed contracts to be entered into with residents and insurance contracts between an operator and an insurer requiring the insurer to assume, wholly or in part, the cost of medical or health related services to be provided to a resident;

(ii) the superintendent of financial services as to the rates and rating methodology, if any, to be used by the operator to determine any entrance fee, monthly care fee and/or any separate charges for the housing component of the continuing care contract including but not limited to a cooperative or condominium fee charged to the resident as proposed in said operator's application for certificate of authority. Subsequent increases in any entrance or monthly care fee in excess of fees calculated pursuant to the approved rating methodology shall require approval of the superintendent. The term "rating methodology" as used herein shall incorporate a combination of variables including but not limited to a pricing structure for comparable services, projected operating and health care costs and the applicable inflationary impact thereon, projected income and occupancy rates and the refundability component of the continuing care retirement contract;

(iii) the superintendent of financial services as to any monthly care fee charged to a resident which may be increased or decreased subject to approval by the superintendent of financial services, provided, that monthly care fees may be increased or decreased without specific approval as long as such increase or decrease does not exceed a relevant cost index or indices which reflect all components of continuing care including the costs associated with provision of health care as determined and promulgated at least annually by the superintendent, and provided further that the superintendent is notified of any such increase or decrease prior to its taking effect;

(iv) an individual resident's monthly care fee shall not be modified because of the increased need for services of that resident;

b. the commissioner as to those aspects of the application relating to

adult care facility beds, if any;

c. the public health and health planning council as to the establishment of a skilled nursing facility by the applicant and as to such other facilities and services as may require the public health and health planning council's approval of the application; provided, however, that the recommendations of the health systems agency having geographical jurisdiction of the area where the continuing care retirement community is located shall not be required with respect to the establishment of an on-site or affiliated residential health care facility to serve residents as part of the continuing care retirement community, for up to the total number of residential health care facility beds provided for in subdivision five of this section in communities statewide;

d. the commissioner under section twenty-eight hundred two of this chapter; provided, however, that, the recommendations of the public health and health planning council and the health systems agency having geographical jurisdiction of the area where the continuing care retirement community is located shall not be required with respect to the construction of an on-site or affiliated residential health care facility to serve residents as part of the continuing care retirement community, for up to the total number of residential health care facility beds provided for in subdivision five of this section in communities statewide; and

e. the attorney general, as to those aspects of the application relating to a cooperative, condominium or other equity arrangement for the independent living unit, if any.

5. Up to two thousand residential health care facility beds, as authorized herein, that may be approved as components of continuing care retirement communities shall not be considered by the department and the health systems agencies in the determination of public need for residential health care facility services; provided, however, that if the community seeking to construct such beds does not provide life care to all residents, it must adequately make the assurances required by

subdivision two of section forty-six hundred twenty-four of this article.

6. If the approvals required by subdivision four of this section have been obtained, the commissioner shall either approve or reject the application. In order to approve the application, the commissioner shall have determined that:

a. the proposed community will meet a need and will fulfill the purposes of this article;

b. the applicant has satisfied the requirements of this article;

c. the applicant has demonstrated to the satisfaction of the council that the applicant and members of the board, officers, and controlling persons of the applicant, are of such character, experience, competence and standing in the community as to give reasonable assurance of their ability to conduct the affairs of the proposed continuing care retirement community in the best interest of the community and in the public interest, and to provide proper care to residents. In the case of an applicant that is controlled, the council must be satisfied that the controlling person has also acted in a manner that is consistent with the public interest;

d. the applicant has otherwise demonstrated the capability to organize, market, manage, promote and operate the community and can be expected to meet its obligations in accordance with this article and in accordance with its contracts with residents;

e. the applicant has demonstrated that the total number of beds for the nursing facility component and the adult care facility bears a reasonable relation to the number of independent living units proposed for such community; and

f. with respect to communities which include a residential health care facility which does not require establishment approval under section twenty-eight hundred one-a of this chapter, the applicant has sufficient

financial resources and sources of future revenues for the operation of the residential health care facility component.

7. Any change in the legal entity operating the continuing care retirement community, or in a controlling person of the community shall require approval in the same manner as an original application; provided, however, that the commissioner may waive any requirement to provide information that is not relevant to such change and provided, further, that the continued public need for the community shall be presumed.

8. The operator shall designate and make knowledgeable personnel available to prospective residents to answer questions about any information contained in the disclosure statement or contract. The disclosure statement and the contract shall each state on the cover or top of the first page in bold twelve point print the following "This matter involves a substantial financial investment and a legally binding contract. In evaluating the disclosure statement and the contract prior to any commitment, it is recommended that you consult with an attorney and financial advisor of your choice, if you so elect, who can review these documents with you."

9. The commissioner shall issue the certificate of authority to the applicant upon approval of the application.

§ 4604-a. Commissioner approval required for industrial development agency financing in connection with continuing care retirement communities. 1. No person seeking financing in connection with a continuing care retirement community through an industrial development agency shall undertake such financing without the prior approval of the commissioner. Upon approving a proposed financing pursuant to this section, the commissioner shall issue a certificate of authorization to the applicant.

2. Prior to approving such financing, the commissioner shall find that:

a. The operator has (i) executed contracts for at least seventy percent of all living units and has on deposit at least ten percent of the entrance fees or purchase price for such units; or (ii) executed contracts for at least sixty percent of all living units and has on deposit at least twenty-five percent of the entrance fees or purchase price for such units.

b. The operator has demonstrated capability to comply fully with the requirements for a certificate of authority and has obtained a contingent certificate of authority pursuant to section forty-six hundred four of this article and the operator has agreed to meet the requirements of article eighteen-A of the general municipal law.

c. The applicant is a not-for-profit corporation as defined in section one hundred two of the not-for-profit corporation law that is (i) eligible for tax-exempt financing under this section and (ii) is exempt from taxation pursuant to section 501(c)(3) of the federal internal revenue code, and either has (i) an equity position in the community equivalent to no less than fifteen percent of the amount to be financed in the aggregate; or (ii) covenants (A) to meet a ratio of cash and investments to outstanding debt (reserve ratio) of no less than twenty-five percent commencing at the end of the first quarter after twenty-four months from the receipt of a certificate of occupancy for the facility, and (B) to maintain that reserve ratio, as tested quarterly based upon the facility's interim financial statements and annually based upon audited financial statements, until debt reduction equal to twenty-five percent of total indebtedness is accomplished; and (c) to reduce total debt by twenty-five percent of the total indebtedness at the time the certificate of occupancy is received by no later than five years after the receipt of the certificate of occupancy.

d. The operator has submitted in connection with the proposed financing a financial feasibility study, including a financial forecast and market study prepared by an independent firm nationally recognized for continuing care retirement community feasibility studies, demonstrating to the satisfaction of the commissioner the financial

soundness of the financing. In addition, the operator has submitted an analysis of economic costs and benefits, including job creation and retention, the estimated value of tax exemptions provided, the project's impact on local businesses and the availability and comparative cost of alternative financing sources. Such analysis shall be prepared by an independent entity.

e. The operator will establish and maintain a fully funded debt service reserve equal to the sum of maximum annual debt service (interest plus annual scheduled principal payments, not including balloon maturities, if any) on bonds authorized thereby having a maturity of ten years or less, plus the maximum annual debt service on bonds authorized thereby having a maturity of greater than ten years, provided, however, that in the case of tax-exempt bond issues, such debt service reserve shall not exceed the maximum amount permitted by federal tax law.

f. The operator will provide for such remedies or limitations of remedies of bondholders as may be required by or consistent with the provisions of this article and any regulations in existence at the time of the issuance promulgated thereunder.

g. Unless all residents or continuing care at home contract holders have life care contracts, the operator has adequately made the assurances required by subdivision two of section forty-six hundred twenty-four of this article and has agreed to fund the liability in the event that such resident's or contract holder's assets are insufficient to pay for nursing facility services for a one year period.

3. In addition, an operator which is subject to the provisions of this section shall:

a. provide the commissioner with notice of any monetary default or covenant default in connection with such financing and shall further notify the commissioner of any withdrawal from the debt service reserve fund established in connection with such financing;

b. respond in writing to the operational recommendations of the commissioner with respect to protecting the interests of continuing care retirement community residents in the event of any monetary default or covenant default provided for in connection with such financing;

c. provide adequate security for the repayment of the bonds issued, including the granting of liens on real and personal property and the pledge of project revenues; the maintenance of minimum debt service coverage and other financial ratios as shall be required in regulations in existence at the time of issuance by the commissioner; and restrictions on other debt and expenditures; and

d. undertake to maintain the financial feasibility of the facility, including the retention of an independent consultant to recommend and help implement remedial action.

4. The commissioner may request, and shall receive, the technical assistance of any state agency or state public authority in performing its functions under this article.

§ 4605. Certificate of authority; authority of operator. 1. A certificate of authority shall authorize an operator:

a. to operate a continuing care retirement community and to enter into contracts pertaining to such community;

b. to prepare and make public information that details the terms of any contract relating to a community;

c. to advertise the community and the related services that will be provided pursuant to this article; and

d. to offer and execute contracts, including the collection of entrance fees and deposits pursuant to section forty-six hundred eight of this article.

2. a. The commissioner, in consultation with the council, may authorize an operator of a community with an on-site or affiliated residential health care facility to provide, for a limited period, residential health care facility services to persons, who are not residents of the community, provided, however, that the operator shall not discriminate in the admission, retention or care of any such person because such person is or will be eligible for, or receives or will receive, medical assistance benefits pursuant to title eleven of article five of the social services law.

b. The commissioner, in consultation with the council, may authorize an operator of a community with an on-site or affiliated adult care facility to provide, for a limited period, adult care facility services to persons, who are not residents of the community, provided, however, that the operator shall not discriminate in the admission, retention or care of any such person because such person is or will be eligible for, or receives or will receive, medical assistance benefits pursuant to title eleven of article five of the social services law or supplemental security income benefits pursuant to title sixteen of the federal social security act and any additional state payments made under title six of article five of the social services law.

§ 4605-a. Certificate of authority; authority to offer continuing care at home contracts. A continuing care retirement community may offer continuing care at home contracts upon approval by the commissioner to amend the continuing care retirement community's certificate of authority. In order to qualify for an amendment to its certificate of authority, the continuing care retirement community shall submit to the commissioner the following:

1. a business plan to the commissioner and the superintendent that includes the following:

(a) a description of the continuing care at home services that will be provided, the market that will be served by the continuing care at home contracts, and the fees to be charged to prospective continuing care at home contract holders;

(b) a copy of the proposed continuing care at home contract; and
(c) an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries demonstrating the impact that the continuing care at home contracts will have on the overall operations of the continuing care retirement community and further demonstrating that the addition of continuing care at home contracts will not jeopardize the financial solvency of the continuing care retirement community.

2. a market feasibility study demonstrating to the commissioner and the superintendent sufficient consumer interest in continuing care at home contracts and further demonstrating that the addition of continuing care at home contracts will not have an adverse impact on the provision of services to continuing care retirement contract holders.

3. materials that meet all requirements established by the New York state department of financial services.

4. a copy of the notification sent to continuing care retirement contract holders describing the anticipated impact of the addition of continuing care at home contracts on continuing care retirement community resources and proof that such notification has been distributed to all continuing care retirement contract holders.

§ 4605-b. Certificate of authority; limitation on continuing care at home contracts. The number of continuing care at home contracts approved on a certificate of authority shall be limited to:

1. The number of approved living units on the continuing care retirement community's premises that are intended for ILU residents, except that the commissioner may approve additional contracts upon a submission by an operator consistent with the provisions set forth in section forty-six hundred five-a of this article;

2. The demonstrated number of continuing care at home contract holders that can be supported in the existing or approved future capacity of the

adult care facility and skilled nursing facility consistent with the provisions set forth in section forty-six hundred five-a of this article; and

3. Conditions set forth by the New York state department of financial services, based upon the superintendent's assessment of the following:

(a) the overall financial impact on the community; and

(b) the submitted materials set forth in section forty-six hundred five-a of this article.

§ 4606. Initial disclosure statement. Prior to the execution of a contract, or before the transfer of any money, other than a refundable priority reservation fee or non-refundable priority reservation agreement application fee, to an operator by or on behalf of a prospective resident, whichever occurs first, the operator shall deliver to the person with whom the contract is to be entered into or the person's legal representative the most recent annual statement as required by section forty-six hundred seven of this article, and an initial disclosure statement which contains the following:

1. The information contained in the contract, unless a copy of such contract is attached to and made a part of the initial disclosure statement, together with full disclosure of the use of any fees and charges in connection with the contract, including entrance fees;

2. The information required in paragraph i and subparagraphs (ii), (iii) and (iv) of paragraph j of subdivision two of section forty-six hundred four of this article;

3. The name and business address of the provider and a statement of whether the provider is an individual, partnership, corporation, or other legal entity;

4. The name and address of any person whose name is required to be provided pursuant to subdivisions two and three of this section and any professional service, firm association, foundation, trust, partnership,

corporation, or any other business or legal entity in which such person has, or which has in such person, a ten percent or greater interest and which it is presently intended will or may provide goods, leases, or services to the provider of a value of five hundred dollars or more, within any year, including a description of the goods, leases or services and the probable or anticipated cost thereof to the provider;

5. If the facility is to be operated by a manager:

a. the identities of any other facilities managed by said individual or entity and a copy of the agreement currently in effect or to be entered into between the provider and the manager for the operation of the facility;

b. if the manager is incorporated or established and operated on a for-profit basis, the identity of all individuals or entities holding any ownership or beneficial interest in the manager, and fees or any other compensation anticipated to be paid by the provider to the manager for the operation of the facility; and

c. the method by which the manager was chosen to manage the facility and, if the manager was chosen because of a condition in a mortgage commitment to the provider, the identity of the mortgagee requiring the condition in the commitment.

6. A description of the proposed or existing facility, including the location, size and anticipated completion date if not completed;

7. A statement as to whether the applicant was or is affiliated, or has a contractual relationship, with a religious, charitable, or other nonprofit organization, the extent of any such affiliation or contractual relationship, and the extent to which the nonprofit organization will be responsible for the financial and contractual obligations of the applicant;

8. If the facility is already in operation or if the applicant operates one or more similar facilities within or outside of this state,

a statement of the changes in the scope of or the rates for care or services provided, including tables showing the frequency and average dollar amount of each increase in periodic rates at each such facility for the previous five years or such shorter period as the facility may have been operated by the provider;

9. If the applicant is the subsidiary corporation or the affiliate of another corporation, a statement identifying the parent corporation or the other affiliate corporation, the primary activities of such parent, or other affiliate corporation, the interest in the applicant held by such parent or other affiliate corporation, and the extent to which the parent corporation will be responsible for the financial and contractual obligations of the subsidiary;

10. Most recent financial statement of the provider prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by an independent certified, or public accountant, including a balance sheet as of the end of the provider's last fiscal year and income statements for the last two fiscal years, or such shorter period of time as the provider has been in operation;

11. If construction, lease, rental, or purchase of the facility has not yet been completed, a statement of the anticipated source and application of the funds to be used in such purchase, lease, rental, or construction, including but not limited to:

a. an estimate of the cost of purchasing, leasing, renting, constructing and equipping the facility, including, but not limited to, such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs that the provider expects to incur or become obligated for prior to the commencement of occupancy;

b. an estimate of the total entrance fees to be received from residents upon completion of occupancy;

c. a description of any mortgage loan or the other long-term financing

intended to be used for the financing of the facility, including the anticipated terms and costs of such financing;

d. an estimate of any funds which are anticipated to be necessary to fund start-up losses and to assure full performance of the obligations of the operator pursuant to life care contracts including, but not limited to, any reserves required pursuant to section forty-six hundred eleven of this article;

e. a projection of estimated income from fees and charges other than entrance fees, a description of individual rates anticipated to be charged, and the assumptions used for calculating the estimated occupancy rate of the facility;

f. a projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses and separate allowances, if any, the replacement of equipment and furnishings and any anticipated major structural repairs or additions;

g. identification of assets pledged as collateral for any purpose;

h. an estimate of assets pledged as collateral for any purpose; and

12. A statement indicating that community residents who are enrolled in a health maintenance organization may have nursing facility benefits available under both the health maintenance organization subscriber contract and the continuing care retirement contract. Such statement shall also indicate that if the health maintenance organization and the community cannot reach an agreement on appropriate financial arrangements, then the resident may have to be admitted to a facility approved by the health maintenance organization in order to receive their Medicare benefit for nursing facility services under the health maintenance organization subscriber contract.

13. The initial disclosure statement and marketing materials of a continuing care retirement community must clearly include a description

of the services offered as part of its contract, including, but not limited to, any limitations on nursing facility services. The initial disclosure statement and marketing materials of a continuing care retirement community which offers various types of contracts, which may include life care contracts, must clearly differentiate among the various types of contracts which it may offer.

14. In accordance with regulations promulgated by the council, the operator shall prepare a standard information sheet for each approved continuing care retirement community, which must be approved by the department of health, distributed with the community's marketing materials and attached to the initial disclosure statement prepared in accordance with this section. The standard information sheet shall be prepared in plain language and in twelve point type and shall include but shall not be limited to the following information:

- a. a brief description of the community, including its name and location and amenities and services, including meal options, available;

- b. the name, address, and telephone number of the operator and a contact person employed by the operator;

- c. the number and types of independent living units, adult care facility units and nursing home beds and whether such beds are on-site or off-site;

- d. the types of contracts available;

- e. a listing of all fees, charges, and refund options and the services covered by such fees and charges;

- f. any insurance coverage required of residents; and

- g. any other information which the continuing care retirement community council determines will assist a consumer in comparing the benefits and costs of different continuing care retirement communities.

15. Any other information as may be required by regulations promulgated by the council.

§ 4607. Annual statement. 1. Within four months of close of the operator's fiscal year, unless an extension of time to file has been granted, the operator shall file an annual statement with the commissioner and superintendent showing the condition as of the last day of the preceding calendar or fiscal year. If the commissioner and superintendent do not receive the annual statement within four months of the end of the operator's fiscal year or have not granted an extension of time to file, the commissioner may charge a late fee.

2. The annual statement shall be in such form as the commissioner prescribes and shall contain at least the following:

a. Any change in status with respect to the information required to be submitted pursuant to section forty-six hundred four of this article;

b. Financial statements audited by an independent certified public accountant, which shall contain, for two or more periods if the community has been in existence that long, the following:

(i) an accountant's opinion and, in accordance with generally accepted accounting principles:

(A) a balance sheet,

(B) a statement of income and expenses,

(C) a statement of equity or fund balances,

(D) a statement of changes in financial position,

(ii) notes to the financial statements considered customary or necessary to ensure full disclosure of the financial statements, financial condition, and operation;

c. A detailed listing of the assets maintained for the reserves;

d. A copy of the most recent actuarial review of the community, including such information as may be required by the superintendent including an opinion of a qualified consulting actuary, as to the

current and projected soundness of the community, provided however that a new actuarial review must be submitted triennially; and

e. Such other reasonable financial and other information as the commissioner and superintendent may require with respect to the operator or the community, or its directors, controlling persons, trustees, members, branches, subsidiaries or affiliates to determine the financial status of the community and the management capabilities of the operator.

3. Sixty days before commencement of each calendar or fiscal year or official opening date, whichever is applicable, each operator shall file with the commissioner and superintendent a computation of the annual long-term debt service and a projected annual revenue and expense summary for the next ten years.

§ 4608. Contracts. A continuing care retirement contract or continuing care at home contract shall contain all of the following information in no less than twelve point type and in plain language, in addition to any other terms or matter as may be required by regulations adopted by the council and issued by the superintendent:

1. The amount of all money transferred, including, but not limited to, donations, subscriptions, deposits, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents or continuing care at home contract holder or holders;

2. A description of all services which are to be furnished by the operator, a description of any fees in addition to the entrance fee and periodic charges provided for in the contract, and the conditions under which the fees may be adjusted, provided that an operator shall not charge any non-refundable application fee to a prospective resident who has paid a non-refundable priority reservation agreement application fee;

3. The procedures of the community relating to a resident's or contract holder's failure to pay the required monthly fees;

4. A statement of the figures and terms concerning the entry of a spouse to the community and the consequences if the spouse does not meet the requirements for entry;

5. A statement of the terms and conditions under which a contract may be cancelled by the operator or by a resident or contract holder and the conditions under which all or any portion of the entrance fee will be refunded by the operator, including the mandatory refund provisions set forth in sections forty-six hundred nine and forty-six hundred ten of this article;

6. a. The procedures and conditions under which a resident may be transferred from his or her living unit or home including a statement that, at the time of transfer, the resident will be given the reasons for the transfer; the process by which a transfer decision is made; the persons with the authority to make the decision to transfer; a description of any change in charges to be paid by the resident for services not covered by the contract fees as a result of the transfer; and a statement regarding the disposition of and the right to return to the living unit in cases of temporary and permanent transfers.

b. For continuing care retirement contracts, the circumstances under which a living unit may be considered vacant and eligible for transfer or resale to a new resident, either due to the permanent transfer of a resident to the community's nursing or other specialized facility or due to the permanent transfer of a resident to a hospital or other facility outside of the community; provided, however, that nothing therein shall relieve a community from its obligations to provide or to insure provision of all contractually required care pursuant to the terms of a continuing care retirement contract. Should a resident's chronic condition require placement in a more specialized chronic care facility that provides services beyond those provided through the community's nursing facility, the liability of the community pursuant to the terms of a continuing care retirement contract shall be equal to the current per diem rate of the nursing facility minus the pro rata apportionment of the resident's monthly fee for the period of care required by the

contract. Nothing herein shall obligate a continuing care retirement community which does not have a life care contract with a resident to provide or pay for a level of nursing facility services nor for any duration beyond what is specifically described in its continuing care retirement contract with that resident. This section shall not affect the operator's obligation under subdivision two of section forty-six hundred twenty-four of this article;

7. For continuing care retirement contracts, a statement that, if the resident dies prior to occupancy date or, through illness, injury, or incapacity is precluded from becoming a resident under the terms of the contract, the contract is automatically rescinded and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except for those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by the parties to the contract;

8. For continuing care at home contracts, a statement that, if the resident dies prior to the effective start date of services or, through illness, injury, or incapacity is precluded from meeting the eligibility terms of the contract, the contract is automatically rescinded and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except for those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by the parties to the contract;

9. For continuing care retirement contracts, a statement of the conditions under which all or any portion of the entrance fee will be released to the operator before the living unit becomes available for occupancy, and a statement of the conditions under which all or any portion of that fee will be refunded in the event of the death of the resident and/or spouse following occupancy of a living unit, including the mandatory refund provisions set forth in section forty-six hundred nine of this article;

10. A statement of the advance notice to be provided the resident or contract holder, of not less than sixty days, of any change in fees or

charges or scope of care or services;

11. A statement that no act, agreement, or statement of any resident or contract holder, or of an individual purchasing care for a resident or contract holder under any agreement to furnish care to the resident or contract holder, shall constitute a valid waiver of any provision of this article or of any regulation enacted pursuant thereto intended for the benefit or protection of the resident or contract holder or the individual purchasing care for the resident or contract holder;

12. For continuing care retirement contracts, a description of the reinstatement policies if a resident leaves the facility or the contract is cancelled; and for continuing care at home contracts, a description of policies if the home resident relocates their private residence or the contract is cancelled.

13. A statement that internal procedures to resolve disputes and grievances have been established, and residents and contract holders notified of them;

14. A statement of the grace period, if any, for the payment of periodic fees without a penalty, and the extent of any penalty for the late payment thereof;

15. A statement that: a. the resident or contract holder, as applicable shall, if eligible, enroll in medicare parts a and b or the equivalent and shall continue to maintain that coverage, together with medicare supplement coverage at least equivalent in benefits to those established by the superintendent as minimum benefits for medicare supplement policies;

b. if the resident or contract holder fails to maintain medicare coverage and a medicare supplement coverage, or is ineligible for such coverage and fails to purchase the equivalent of such coverage, the community shall purchase the coverage or equivalent coverage on behalf and at the expense of the resident or contract holder and shall have the authority to require an appropriate adjustment in payments by the

resident or contract holder to the community;

c. if the community cannot purchase medicare coverage and medicare supplement coverage or the equivalent, the community shall have the authority to require an adjustment in monthly fees, subject to the approval of the superintendent, to fund the additional risk to the facility; and

d. if the resident or contract holder fails to purchase or maintain medicare coverage and medicare supplement coverage or the equivalent, and the community has not purchased such coverage, the community will be responsible for any expenses which would have been covered by medicare and medicare supplement coverage. The community may add the amount of such expenses to the resident's or contract holder's monthly fees.

16. A statement that any amendment to the contract and any change in fees or charges, other than those within the guidelines of an approved rating system, must be approved by the superintendent of financial services;

17. A statement that property shall not be substituted as payment for either the entrance fee or monthly fee;

18. A statement describing the method by which the community will determine priority for access to available adult care facility or nursing facility beds between a continuing care retirement contract holder and a continuing care at home contract holder;

19. For continuing care retirement contracts, a statement whether the continuing care retirement contract includes any ownership, beneficial or trust interest in the assets of the operator, the assets of the facility, or both. Assets shall include, but are not limited to, property, trusts, reserves, interest and other assets; and

20. Continuing care at home contracts shall include the following:

a. a statement describing the circumstances under which a contract

holder may move into a campus independent living unit, adult care facility or nursing home;

b. a statement as to whether and under what circumstances transportation will be provided to continuing care at home contract holders;

c. a statement describing the mechanism for monitoring continuing care at home contract holders;

d. a statement describing the method by which the community will determine priority for access to available ILUs between a continuing care at home contract holder who wishes to convert the contract to a continuing care retirement contract and a continuing care retirement contract holder;

e. a statement describing any applicable geographical limits of the continuing care at home services, and the policy that will be followed in the event that a continuing care at home contract holder relocates to a different residence outside the geographical limits covered by the continuing care at home contract; and

f. a statement describing any applicable policy that would entitle a continuing care at home contract holder to select adult care facility or skilled nursing facility placement in a facility that is not part of the continuing care retirement community.

§ 4608-a. Continuing care at home requirements. Continuing care retirement communities offering continuing care at home contracts shall:

1. Ensure that all continuing care retirement community employees or contractors providing services to continuing care at home contract holders are duly licensed or certified pursuant to law, which shall include but not be limited to any licensure requirements for the provision of home care services set forth in article thirty-six of this chapter;

2. Include all operating expenses for continuing care at home contracts in the calculation of reserve requirements required by the department of financial services; and

3. Include all operating activities for continuing care at home contracts in the total operation of the community when submitting financial reports as required by the department and the department of financial services.

§ 4609. Withdrawal, death or dismissal of person; refund. 1. Upon the giving of written notice of cancellation by certified mail of at least thirty days, the contract may be cancelled by a resident for any reason, or by an operator if the applicant has willfully mismanaged assets needed to pay monthly care fees. A resident shall not be discharged for inability to pay the monthly fee except where a showing of the willful mismanagement of assets needed to pay monthly care fees has been made.

2. If the notice required by subdivision one of this section is given within the first ninety days of occupancy, the resident shall receive a refund of not less than the entry fee and any other pre-payments less the actual cost of any services actually provided and the actual cost of refurbishing the unit for resale. After the first ninety days of occupancy, any refund shall be not less than the entrance fee, except that the operator may retain no more than two percent per month of occupancy by the resident of such fee and no more than a four percent fee for processing.

3. Refunds upon death will be made on the same basis as refunds upon withdrawal.

4. Any refund made pursuant to this section must be paid no later than thirty days after the formerly occupied unit has been resold, but in no event later than one year after the formerly occupied unit has been vacated.

§ 4610. Entrance fee escrow account. As a condition for approval to advertise and collect refundable entry fees/deposits:

1. The operator shall establish an interest-bearing account with a New York bank, New York savings and loan association, or New York trust company for any entrance fees received by the operator, which escrow funds shall be subject to release as provided by subdivision seven of this section.

2. An escrow agreement shall be entered into between the bank, savings and loan association, or trust company and the operator of the community. The agreement shall state that its purpose is to protect the resident or the prospective resident and that, upon presentation of evidence of compliance with applicable portions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the operator or resident as directed.

3. Checks, drafts, and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

4. All funds deposited in the escrow account shall remain the property of the resident until released to the operator in accordance with this section, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditor's claims against the operator or community.

5. At the request of the operator, the commissioner, or the superintendent, the escrow agent shall issue a statement indicating the status of the escrow account.

6. Escrowed funds shall not be released to the operator unless:

a. construction or purchase of the community has been substantially completed, an occupancy permit covering the living unit has been issued

by the local government having authority to issue such permits, and the living unit becomes available for occupancy; or

b. the operator has submitted an application to the commissioner, on forms approved by the department, for authorization to use escrowed entrance fees to assist the operator in financing the construction or purchase of a proposed community and the commissioner, with the advice of the superintendent, and in accordance with such regulations as may be promulgated by the council, has approved such application. The commissioner shall not approve such application over the objection of the superintendent, and shall not approve it unless satisfied that the following conditions have been met:

(i) the operator has executed contracts accompanied by an entrance fee or entrance fee deposit for at least sixty percent of all proposed living units;

(ii) the aggregate entrance fees or deposits received by the operator pursuant to executed contracts equal at least twenty-five percent of the total of the entrance fees due at occupancy for at least sixty percent of all proposed living units, or at least ten percent of the total entrance fee due at occupancy for at least seventy percent of all proposed living units, whichever is less;

(iii) the operator has entered into a contract for the construction or purchase of the community which contract has a fixed maximum price and, if a construction contract, the contractor has secured a performance or completion bond for the benefit of the operator;

(iv) the operator has received a firm commitment for a permanent mortgage loan or other long term financing and conditions to the commitment prior to disbursement of funds thereunder, other than completion of construction or purchase, are substantially satisfied;

(v) the total amount of escrowed entrance fees or deposits that may be approved for release under this paragraph shall not exceed fifteen percent of the total costs of acquiring, constructing and equipping the proposed community;

(vi) use of the entrance fees or deposits shall not impair the operator's ability to comply with the requirements of section forty-six hundred eleven of this article;

(vii) the operator's executed contracts or amended contracts referred

to in subparagraph (i) of this paragraph, and all contracts generating the entrance fees for which release is sought, contain a provision conspicuously disclosing the intended use of entrance fees, and that all refunds shall be in accordance with the otherwise applicable provisions of this article, the regulations adopted pursuant thereto and the contract;

(viii) the use of the entrance fees or deposits under this paragraph will promote the efficient and cost-effective acquisition or development of the proposed community; and

(ix) the release, availability and use of the entrance fees comply with any other conditions the council shall establish.

7. If the funds in an escrow account under this section and any interest thereon are not released to the operator within such time as provided by rules and regulations adopted by the council, then such funds shall be returned by the escrow agent to the persons who had made payment to the operator.

8. An entrance fee held in escrow may be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the operator that such person is entitled to a refund of the entrance fee.

9. Nothing in this section shall be interpreted as requiring the escrow of any nonrefundable application fee, designated as such in the contract, received by the operator from a prospective resident.

10. Construction of housing or other facilities shall not begin until:

a. the operator has executed contracts accompanied by a deposit of at least ten percent of the entry fee payment for fifty percent of all units; and

b. all permits and approvals necessary for operation of the community have been granted except those that depend upon construction;

Provided, nothing in this subdivision shall prohibit an operator, upon

the approval of the council, or an applicant or prospective applicant upon the approval of the commissioner pursuant to section forty-six hundred twenty-one of this article, from constructing model units and a sales office.

11. Any entry fee deposit required by an operator shall be fully refundable if the contract is cancelled within seventy-two hours of its execution. In the event of cancellation, the entry fee deposit shall be refunded within three business days of receipt of cancellation.

§ 4611. Reserves and supporting assets. 1. An operator shall maintain reserve liabilities and supporting assets in an amount and for the purposes set forth in a regulation issued by the superintendent of financial services. Liquid assets must be maintained for the following reserve liabilities:

a. Principal and interest payments and payments for taxes and insurance for up to twelve months;

b. Total estimated operating costs for up to six months as set by the superintendent;

c. Repairs and replacements for up to twelve months; and

d. In addition, the amount of liquid assets must meet any cash flow requirements and conditions as set forth in a regulation.

2. The assets in support of reserve liabilities of subdivision one of this section shall meet quantitative and qualitative standards set forth in regulations issued by the superintendent.

§ 4612. Residents' organizations. 1. Continuing care retirement contract holders shall have the right of self-organization, the right to be represented by one or more individuals of their own choosing, and the right to engage in concerted activities for the purpose of keeping

informed of the operation of the community in which they live.

2. The board of directors, a designated representative, or other such governing body of a continuing care retirement community shall meet at least four times a year with residents' representatives and shall hold a general meeting of all residents once a year for the purpose of discussing subjects including, but not limited to, the financial position of the community, the quality of social and health services at the community, and any proposed changes in policies, programs or services.

§ 4613. Advertisements. No person, partnership, corporation, company, trust or association, or any agent or employee thereof, shall publish or cause to be published, circulated, or disseminated any financial statement, pamphlet, circular, form letter, advertisement, or other sales literature or advertising communication addressed or intended for distribution to prospective residents of continuing care retirement communities that contains statements or illustrations that are untrue, deceptive, misleading, or omit material facts or omit any other information required by regulations appropriate to a continuing care retirement community.

§ 4614. Audits. 1. The commissioner, or designee; and the superintendent, or designee; may at any time, and shall at least once every three years, visit each community and examine the business of any applicant for a certificate of authority and any operator engaged in the execution of continuing care retirement contracts or continuing care at home contracts or engaged in the performance of obligations under such contracts. Routine examinations may be conducted by having documents designated by and submitted to such commissioners or superintendent, which shall include financial documents and records conforming to commonly accepted accounting principles and practices. The final written report of each such examination conducted by such commissioners or superintendent shall be filed with the commissioner and, when so filed, shall constitute a public record. A copy of each report shall be

provided to members of the continuing care retirement community council. Any operator being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the commissioners or superintendent, respectively may, at any time, examine the records and affairs and inspect the community's facilities, whether in connection with a formal examination or not.

2. Any duly authorized officer, employee, or agent of the health department, or department of financial services may, upon presentation of proper identification, have access to, and inspect, any records maintained by the community relevant to the respective agency's regulatory authority, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this article.

3. Reports of the results of such examinations and inspections shall be kept on file by the commissioner and shall be open to public inspection at the community, provided any records, reports, or documents which by state or federal law or regulation are deemed confidential may not be distributed or made available unless and until such confidential status has expired.

§ 4615. Revocation, suspension or annulment of certificate of authority. 1. The commissioner may revoke, suspend, limit or annul the certificate of authority of an operator upon proof that:

a. The operator failed to continue to meet the requirements for the authority originally granted;

b. The operator lacked one or more of the qualifications for the certificate of authority as specified by this article;

c. The operator made a material misstatement, misrepresentation, or committed fraud in obtaining the certificate of authority, or in attempting to obtain the same;

d. The operator lacked fitness or was untrustworthy;

e. The operator engaged in fraudulent or dishonest practices of management in the conduct of business under the certificate of authority;

f. The operator converted or withheld funds;

g. The operator failed to comply with any provision of this article;

h. The unsound business practices of the operator renders its further transactions in this state hazardous or injurious to the public;

i. The operator has refused to be examined or to produce its accounts, records, and files for examination, or its officers, employees, or controlling persons have refused to give information with respect to the affairs of the community or to perform any other legal obligation as to such examination;

j. The superintendent of financial services has made a determination that the operator is insolvent within the meaning of section one thousand three hundred nine of the insurance law; or

k. The commissioner has found violations of applicable statutes, rules or regulations which threaten to affect directly the health, safety, or welfare of a resident.

2. No certificate of authority shall be revoked, suspended, limited or annulled without a hearing, except that a certificate of authority may be temporarily suspended or limited prior to a hearing for a period not in excess of sixty days upon written notice to the operator following a finding by the commissioner that the public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices that pose an imminent danger to the health or safety of any resident. Any delay in the hearing process occasioned by the operator shall toll the running of said suspension or limitation and shall not abridge the full time provided in

this subdivision.

3. Any state agency which seeks to revoke, suspend, limit or annul the certificate of authority or any other license or certificate required to be obtained by an operator of a continuing care retirement community pursuant to law, shall request the commissioner to commence a hearing pursuant to this section.

4. The commissioner shall fix a time and place for the hearing. The commissioner shall cause to be served in person or mailed by registered or certified mail to the operator at least ten days before the date fixed for the hearing a copy of the charges, together with the notice of the time and place of the hearing. The operator shall file with the commissioner not less than three days prior to the hearing a written answer to the charges. The agency which initiated the proceeding shall be responsible for providing evidence in support of the charges to the commissioner in order to prepare a statement of charges and shall provide evidence in support of the charges at the hearing.

5. All orders hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review must be made within sixty days after service in person or by registered or certified mail of a copy of the order upon the operator.

§ 4616. Appointment of a caretaker. Upon a determination by the commissioner that there exists operational deficiencies in a continuing care retirement community that show:

1. a condition or conditions in substantial violation of the standards for health, safety or patient care established under federal or state law or regulations; or

2. that there exists in the facility a pattern or practice of habitual violation of the standards of health, safety or patient care established under federal or state law or regulations, the commissioner shall take

the actions prescribed by section forty-six hundred fifteen of this article, and, where the commissioner deems it to be in the public interest, the commissioner shall petition a court of competent jurisdiction to appoint a caretaker as defined in section twenty-eight hundred one of this chapter. The petition, the proceedings, and the procedures for appointment of a caretaker shall be governed by the provisions of section forty-six hundred seventeen of this article, and the powers, duties and rights of a caretaker appointed pursuant to such section shall be the same as those authorized by subdivision four of such section.

§ 4617. Receiverships. 1. The commissioner may, upon a determination that serious operational deficiencies exist or serious financial problems exist and such action is desirable, enter into an agreement with the operator or owners of a continuing care retirement community with respect to the appointment of a receiver to take charge of the community under conditions as found acceptable by both parties. Receivership commenced in accordance with the provisions of this subdivision shall terminate at such time as may be provided in the receivership agreement, or at such time as either party notifies the other in writing that it wishes to terminate such receivership.

2. The commissioner shall, at the time of revocation, suspension or temporary suspension of a certificate of authority, apply to the supreme court where the community is situated for an order directing the owner of the land and/or structure on or in which the community is located, to show cause why a receiver should not be appointed to take charge of the community. In those cases where the certificate of authority has been revoked, suspended or temporarily suspended, the supreme court shall appoint a receiver that, where reasonably possible, is a legal entity that holds a valid certificate of authority. Such application shall contain proof by affidavit that the facility has had its certificate of authority revoked, suspended, or temporarily suspended. Such order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy thereof and the papers on which it is based, on the owner or owners of the land

and/or structures on or in which the community is located. If any such owner and manager cannot with due diligence be served personally within the county where the property is located and within the time fixed in such order, then service may be made on such person by posting a copy thereof in a conspicuous place within the community in question, and by sending a copy thereof by registered mail, return receipt requested, to such owner at the last address registered by such owner with the department or in the absence of such registration to the address set forth in the last recorded deed with respect to the facility. Service shall be deemed complete on filing proof of service thereof in the office of the county clerk, or the clerk of the city of New York, as the case may be.

3. On the return of said order to show cause, the matter shall have precedence over every other business of the court unless the court shall find that some other pending proceeding, having a similar statutory precedence, shall have priority. The court may conduct a hearing at which all interested parties shall have the opportunity to present evidence pertaining to the application. If the court shall find that the facts warrant the granting thereof, then any such qualified and approved agency, person or corporation, or the commissioner or any person designated by the commissioner, shall be appointed receiver to take charge and assume operation of the community. However, such receiver may make application to the appointing court for decision, reformation or such other relief as may be appropriate to protect the best interests of the residents residing within such community. No security interest in any real or personal property comprising the community shall be impaired or diminished in priority by the receiver. The receiver shall compensate the owner or owners of any goods held in inventory for those goods which he or she uses or causes to be used by reimbursing the costs of such goods, except that no such compensation shall be made for any goods for which the owners or operators of the community have already been reimbursed.

4. Any receiver appointed pursuant to this section shall have all of the powers and duties of a receiver appointed in an action to foreclose a mortgage on real property, together with such additional powers and

duties as are herein granted and imposed. The receiver may correct or eliminate those deficiencies in the facility that seriously endanger the life, health, safety or finances of such residents subject to such terms as the court may direct. The receiver shall operate the community in such a manner as intended to assure safety and adequate care for such residents. Any receiver who is an official or employee of the state of New York shall not be required to file any bond. The receiver shall honor all existing leases, mortgages and chattel mortgages that had previously been undertaken as obligations of the owners or operators of the community.

5. The appointing court, upon application of the receiver, may make such provision as justice may require for reasonable compensation and reimbursement of the reasonable expenses of the receiver. The receiver shall be liable only in his or her official capacity for injury to person and property by reason of conditions of the community in a case where an owner would have been liable; provided that he or she operates such facility in compliance with the terms of his or her appointment, the receiver shall not have any liability in his or her personal capacity, except for gross negligence and intentional acts.

6. a. The court shall terminate the receivership only under the following circumstances:

(i) when the community is issued a new certificate of authority for the community; or

(ii) at such time as all of the residents in the community have been provided alternate residential and health care services.

b. At the time of termination, the receiver shall render a full and complete accounting to the court and shall make disposition of surplus money at the discretion of the court.

7. a. Any person who is served a copy of an order of the court appointing the receiver shall, upon being notified of the name and address of the receiver, make all payments for goods supplied by the community, or services rendered by the community, to the receiver. A receipt shall be given for each such payment, and copies of all such

receipts shall be kept on file by the receiver. The amount so received shall be deposited by the receiver in a special account which shall also be used for all disbursements made by the receiver.

b. Any person refusing or omitting to make such a payment after such service and notice may be sued therefor by the receiver. Such person shall not in such suit dispute the authority of the receiver to incur or order such expenses, or the right of the receiver to such payments made to him. The receipt provided by the receiver for any sum paid to him shall, in all suits and proceedings and for every other purpose, be as effectual in favor of any person holding the receipt as actual payment of the amount thereof to the operator or other person or persons who would, but for the provisions of this section, have been entitled to receive the sum to be paid. No resident shall be discharged, nor shall any contract or rights be forfeited or impaired, nor any forfeiture or liability be incurred, by reason of any omission to pay any operator, owner, contractor, or other person any sum so paid to the receiver.

8. Any other provision of this article notwithstanding, the commissioner may, if such commissioner deems appropriate, grant to any community operating or scheduled to operate under a receivership authorized by this section a certificate of authority, the duration of which shall be limited to the duration of the receivership.

9. a. No provision contained herein shall be deemed to relieve the operator, owner, or manager of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the operator, owner, or manager prior to the appointment of any receiver hereunder, nor shall anything contained herein be construed to suspend during the receivership any obligation of the owner for the payment of taxes or other operating and maintenance expenses of the community nor of the owner or any other person for the payment of mortgages or liens.

b. The receiver shall not be responsible for any obligations incurred by the owner, manager, or prime lessor, if any, prior to the appointment of the receiver, other than those obligations to residents pursuant to the continuing care retirement contracts.

c. The receiver shall be entitled to use for operating and maintenance expenses and the basic needs of the residents of the community a portion of the revenues due the operator during the month in which the receiver is appointed which portion shall be established on the basis of the amounts of the unpaid operating and maintenance expenses for such month.

§ 4618. Civil action. Any person who, as or on behalf of an operator, enters into a contract without having first delivered to the prospective resident the disclosure statement and annual report required by sections forty-six hundred six and forty-six hundred seven of this article; or delivers to the prospective resident a disclosure statement or annual report that omits a material fact or makes an untrue or misleading statement of material fact shall be liable to the individual contracting for services pursuant to such contract for damages and repayment of all entrance, application, periodic charge, or other fees paid by such person, less the reasonable cost of care and housing provided until discovery of the violation or until the violation should reasonably have been discovered, together with interest, costs, and reasonable attorney's fees.

§ 4619. Criminal penalties. 1. A person, partnership, corporation, controlling person, or agent or employee thereof, who knowingly uses or employs any act or practice in violation of this article shall be guilty of a class A misdemeanor.

2. Nothing under this article limits the power of the state to punish any person for any conduct which also constitutes a separate crime under any other statute.

3. The council may refer such evidence as is available concerning violations of this article to the appropriate district attorney who may, with or without such reference, institute appropriate criminal proceedings.

§ 4620. Separability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this article directly involved in the controversy in which the judgment shall have been rendered.

§ 4621. Priority reservation agreements; prior to obtaining a certificate of authority. The provisions of this section shall apply to entities that seek approval to enter into priority reservation agreements and to solicit, collect or receive priority reservation fees, with respect to a proposed continuing care retirement community, prior to obtaining a certificate of authority under this article.

1. No person, partnership, corporation or other entity shall solicit, collect or receive any priority reservation fee or enter into any agreement relating to the payment of any priority reservation fee with respect to any continuing care retirement community to be operated within the state without first obtaining the written authorization of the commissioner. The commissioner shall not grant such authorization to an entity that has not yet obtained a certificate of authority unless the requirements of this section and any applicable regulations are met. Upon obtaining the authorization of the commissioner under this section, a prospective continuing care retirement community applicant or an entity that has filed an application for a certificate of authority may enter into cancelable priority reservation agreements with prospective residents and solicit, collect and receive refundable priority reservation fees for direct deposit into an escrow account, prior to obtaining a certificate of authority, for the purpose of evaluating market demand for a proposed continuing care retirement community and for the purpose of guaranteeing to prospective residents an opportunity for priority placement in a continuing care retirement community. A priority reservation fee shall not exceed two thousand dollars unless the commissioner, in the discretion of such commissioner, establishes

that a priority reservation fee may exceed two thousand dollars. A non-refundable priority reservation agreement application fee shall not exceed the maximum amount established by the commissioner, in such commissioner's discretion.

2. In order to receive authorization by the commissioner to enter into cancelable priority reservation agreements and to solicit, collect or receive any refundable priority reservation fee, a person, partnership, corporation or other entity, hereinafter designated as the applicant, shall apply for such authorization on forms or in a format prescribed by the commissioner and, as part of such application, shall submit the following information:

a. a description of the applicant's plan to implement the process of entering into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees;

b. a general description of the proposed community, including the location and description of the proposed community site; the components to be included in the community, such as independent living units, skilled nursing facility and adult care facility; the estimated number of each type of unit or beds; and the services to be provided;

c. an estimate of the pricing structure of the community including entrance fees and monthly care fees;

d. a description of the anticipated market to be served;

e. anticipated methods and sources of financing for the proposed community;

f. organizational structure of the applicant;

g. the name and address of the escrow agent and a copy of the escrow agreement required pursuant to this section;

h. a copy of the instructions to the escrow agent regarding the

issuance of refunds;

i. a copy of the forms to be used to document a request for a refund of a priority reservation fee and the issuance of such refund;

j. a copy of the most recent set of financial statements of the applicant prepared in accordance with generally accepted accounting principles and certified to be true and accurate by an independent certified public accountant;

k. draft copies of all proposed marketing materials, including final marketing materials as soon as available; provided that the provision of such material shall not be construed to require approval of such materials by the department or the council;

l. a description of the sales office and a copy of the preliminary site plans and drawings of any proposed model units;

m. a copy of the proposed priority reservation agreement; and

n. any other information as may be required by regulations adopted pursuant to this article.

3. Any change in the legal entity authorized under this section to enter into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees shall require approval in the same manner as the original application; provided, however, that the commissioner may waive any requirement to provide information that is not relevant to such change.

4. a. As a condition to receiving the commissioner's authorization under this section, an applicant shall establish a government insured interest-bearing account, which earns interest at a rate which is consistent with prevailing interest rates, and enter into an escrow agreement with a New York bank, New York savings and loan association or New York trust company for the deposit of any priority reservation fees collected by the applicant pursuant to this section, which escrow funds

shall be subject to release as provided for in this section.

b. The escrow agreement shall state that its purpose is to protect prospective residents who have paid a priority reservation fee to the applicant in furtherance of the applicant's efforts to evaluate market demand for a proposed continuing care retirement community and to guarantee prospective residents an opportunity for priority placement in a continuing care retirement community and that, upon presentation of evidence of compliance with applicable portions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the applicant, the prospective resident or the prospective resident's legal representative as directed, within fifteen business days of receipt of the notice by the escrow agent.

c. Checks, drafts, and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

d. All funds deposited in the escrow account shall remain the property of the prospective residents until released to the applicant in accordance with this section, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the applicant.

e. At the request of the applicant, the commissioner, or a prospective resident, the escrow agent shall issue a statement indicating the status of the escrow account.

f. A prospective resident's escrowed funds shall not be released to an applicant unless the applicant obtains a certificate of authority to operate the proposed continuing care retirement community and to enter into continuing care retirement contracts, and the prospective resident has entered into a continuing care retirement contract with the applicant and has elected to apply the priority reservation fee to an actual entrance fee or deposit on an entrance fee. Upon release to the approved applicant, a prospective resident's escrowed priority

reservation fee funds shall be deposited into the entrance fee escrow account provided for in section forty-six hundred ten of this article.

g. If the funds in an escrow account under this section, and any interest thereon, are not released to the applicant within such time as provided by rules and regulations adopted by the commissioner, then such funds shall be returned by the escrow agent to the person who had made the payments or the person's legal representative.

h. A priority reservation fee, and the interest accrued thereon, held in escrow shall be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the applicant or the person who paid the fee or the person's legal representative that the priority reservation agreement has been cancelled. Any priority reservation fee, and the interest accrued thereon, shall be returned by the escrow agent to the person who paid the fee or the person's legal representative within fifteen business days of receipt by the escrow agent of notice of cancellation of the priority reservation agreement.

i. Refunds of priority reservation fees upon the death of a prospective resident will be made upon the same basis as refunds upon cancellation of a priority reservation agreement.

j. Nothing in this section shall be interpreted as requiring the escrow of any non-refundable priority reservation agreement application fee, designated as such in the cancelable priority reservation agreement, which fee is received by the applicant from a prospective resident.

5. Any marketing materials, including all materials associated with a sales office and model units, used in the solicitation of priority reservation agreements or priority reservation fees shall, at a minimum, contain the following:

a. a statement that the purpose of the marketing material is to determine the market demand for a proposed continuing care retirement community and to offer prospective residents an opportunity for a

guaranteed priority placement in a continuing care retirement community by entering into cancelable priority reservation agreements and accepting refundable priority reservation fees;

b. a statement that the cancelable priority reservation agreement is not a continuing care retirement contract and may be cancelled by the person entering the agreement or the person's legal representative at any time, without cause; and

c. a statement that any priority reservation fees paid shall be held in escrow and shall be refunded, together with interest accrued at prevailing rates, to the person paying the fee or the person's legal representative upon request and cancellation of the priority reservation agreement.

6. Any priority reservation fees with respect to a proposed continuing care retirement community may be collected only after issuance of a cancelable priority reservation agreement to the person paying the fee, which agreement shall contain the following information:

a. the name and location of the proposed community;

b. the name and address of the applicant;

c. the name, address and phone number of a contact person;

d. the name and address of the person paying the fee;

e. the name and address of the escrow agent;

f. the type of unit being reserved;

g. the estimated entry fee and monthly care fee clearly identified as an estimate;

h. the amount of any non-refundable priority reservation agreement application fee;

i. a notice in bold twelve point type that the cancelable priority reservation agreement does not obligate the person entering into the agreement in any way; that there is no guarantee by the applicant that the fees estimated in the agreement will not change; that the community described is only a proposed community and any model units are only representative of units in a proposed community which is subject to the submission of a formal application by the applicant and the subsequent approval or disapproval by the council; that there is no guarantee that the unit described in the agreement or represented by any model will be built or otherwise made available as described in the agreement or at all; that the person paying the priority reservation fee may receive a refund of the fee plus interest accrued at prevailing rates upon request; and that should a certificate of authority be granted that he or she shall be entitled on a priority basis to apply the priority reservation fee to an actual entrance fee or entrance fee deposit on a unit not already under contract;

j. the signature of the person paying the fee and the signature of the applicant or the applicant's agent; and

k. a statement of the effective period of the agreement not to exceed the duration of the commissioner's authorization.

7. a. In order to approve an application under this section, the commissioner shall have determined, as applicable, that:

(i) the applicant has satisfied the requirements of this section and any applicable regulations; and

(ii) the applicant has demonstrated the capability to conduct a market analysis of the demand for the proposed continuing care retirement community and can be expected to meet its obligations in accordance with this section and in accordance with its priority reservation agreements with prospective residents.

b. If the commissioner approves an application, the commissioner shall issue a written authorization to the applicant authorizing the applicant to enter into cancelable priority reservation agreements and collect

refundable priority reservation fees from prospective residents concerning the proposed continuing care retirement community.

c. The commissioner's authorization shall remain in effect for a period not to exceed eighteen months from the date of the commissioner's authorization the commencement of said period to be specifically stated in such authorization subject to the following:

(i) the commissioner may rescind the authorization, including any extension thereof, at any time for just cause, including any material misstatement of fact or misrepresentation in any of the application materials or any materials subsequently disseminated;

(ii) the authorization may be extended upon written application to and approval of the commissioner for the duration of time specified in the commissioner's written approval;

(iii) unless already expired, the authorization shall be extended automatically if an application for a certificate of authority is submitted pursuant to this article, and such authorization shall remain in effect as long as the application for a certificate of authority remains active; and

(iv) unless already expired, the authorization shall be extended automatically if a certificate of authority is obtained by the applicant pursuant to this article, and such authorization shall remain in effect as long as the certificate of authority remains in effect.

d. The applicant shall provide written notice to all parties who have entered into cancelable priority reservation agreements of the following:

(i) notice of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements;

(ii) notice of the commissioner's extension of authorization to enter into cancelable priority reservation agreements including the new expiration date and the reason for such extension; and

(iii) notice upon issuance of a certificate of authority pursuant to this article that the party to the agreement has the option on a priority basis to apply the priority reservation fee to an actual entrance fee or a deposit on an entrance fee.

e. The commissioner shall provide written notice to the escrow agent of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements, including instructions to release funds held in escrow to the persons who have paid refundable priority reservation fees.

§ 4622. Priority reservation agreements; after obtaining a certificate of authority. The provisions of this section apply to entities that seek approval to enter into priority reservation agreements and to solicit, collect or receive priority reservation fees, with respect to a continuing care retirement community, after obtaining a certificate of authority under this article.

1. No person, partnership, corporation or other entity shall solicit, collect or receive any priority reservation fee or enter into any agreement relating to the payment of any priority reservation fee with respect to any continuing care retirement community operated or to be operated within the state without first obtaining the written authorization of the commissioner. The commissioner shall not grant such authorization to an entity that has obtained a certificate of authority unless the requirements of this section and any applicable regulations are met. Upon obtaining the authorization of the commissioner under this section, an operator may enter into cancelable priority reservation agreements with prospective residents and solicit, collect and receive refundable priority reservation fees for direct deposit into an escrow account for the purpose of guaranteeing to prospective residents an opportunity for priority placement in the continuing care retirement community for which the operator has obtained a certificate of authority. A priority reservation fee shall not exceed two thousand dollars unless the commissioner, in the discretion of such commissioner, establishes that a priority reservation fee may exceed two thousand dollars. A non-refundable priority reservation agreement application fee shall not exceed the maximum amount established by the commissioner, in such commissioner's discretion.

2. In order to receive authorization by the commissioner to enter into

cancelable priority reservation agreements and to solicit, collect or receive any refundable priority reservation fee, an operator shall apply for such authorization on forms or in a format prescribed by the commissioner and, as part of such application, shall submit the following information:

a. a description of the applicant's plan to implement the process of entering into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees;

b. the name and address of the escrow agent and a copy of the escrow agreement required pursuant to this section;

c. a copy of the instructions to the escrow agent regarding the issuance of refunds;

d. a copy of the forms to be used to document a request for a refund of a priority reservation fee and the issuance of such refund;

e. draft copies of all proposed marketing materials, provided that copies of the final marketing materials must be submitted as soon as they are available provided further that provision of such materials shall not be construed to require approval of such materials by the department or the council;

f. a description of the sales office and drawings of any proposed model units;

g. a copy of the proposed priority reservation agreement; and

h. any other information as may be required by regulations adopted pursuant to this article.

3. a. As a condition to receiving the commissioner's authorization under this section, an operator shall establish a government insured interest-bearing account, which earns interest at a rate which is consistent with prevailing interest rates, and enter into an escrow

agreement with a New York bank, New York savings and loan association or New York trust company for the deposit of any priority reservation fees collected by the operator pursuant to this section, which escrow funds shall be subject to release as provided for in this section.

b. The escrow agreement shall state that its purpose is to protect prospective residents who have paid a priority reservation fee to the operator in order to guarantee prospective residents an opportunity for priority placement in the continuing care retirement community for which the operator has been issued a certificate of authority and that, upon presentation of evidence of compliance with applicable portions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the operator, the prospective resident or the prospective resident's legal representative as directed, within fifteen business days of receipt of the notice by the escrow agent.

c. Checks, drafts, and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

d. All funds deposited in the escrow account shall remain the property of the prospective residents until released to the operator in accordance with this section, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the operator.

e. At the request of the operator, the commissioner, or a prospective resident, the escrow agent shall issue a statement indicating the status of the escrow account.

f. A prospective resident's escrowed funds shall not be released to an operator unless the prospective resident has elected to apply the priority reservation fee to an actual entrance fee or deposit on an entrance fee. Upon release to the operator, a prospective resident's escrowed priority reservation fee funds shall be deposited into the entrance fee escrow account provided for in section forty-six hundred

ten of this article; provided that the operator may retain such funds and shall not be required to deposit them into the entrance fee escrow account if the prospective resident's living unit is available for occupancy.

g. If the funds in an escrow account under this section, and any interest thereon, are not released to the operator within such time as provided by rules and regulations adopted by the council, then such funds shall be returned by the escrow agent to the persons who had made the payments or the person's legal representative.

h. A priority reservation fee, and the interest accrued thereon, held in escrow shall be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the operator or the person who paid the fee or the person's legal representative that the priority reservation agreement has been cancelled. Any priority reservation fee, and the interest accrued thereon, shall be returned by the escrow agent to the person who paid the fee or the person's legal representative within fifteen business days of receipt by the escrow agent of notice of cancellation of the priority reservation agreement.

i. Refunds of priority reservation fees upon the death of a prospective resident will be made upon the same basis as refunds upon cancellation of a priority reservation agreement.

j. Nothing in this section shall be interpreted as requiring the escrow of any non-refundable priority reservation agreement application fee, designated as such in the cancelable priority reservation agreement, which fee is received by the operator from a prospective resident.

4. Any marketing materials, including all materials associated with a sales office and model units, used in the solicitation of priority reservation agreements or priority reservation fees shall, at a minimum, contain the following:

a. a statement that the purpose of the marketing material is for the

operator to offer prospective residents an opportunity for a guaranteed priority placement in a continuing care retirement community by entering into cancelable priority reservation agreements and accepting refundable priority reservation fees;

b. a statement that the cancelable priority reservation agreement is not a continuing care retirement contract and may be cancelled by the person entering the agreement or the person's legal representative at any time, without cause; and

c. a statement that any priority reservation fees paid shall be held in escrow and shall be refunded, together with interest accrued at prevailing rates, to the person paying the fee or the person's legal representative upon request and cancellation of the priority reservation agreement.

5. Any priority reservation fees with respect to a continuing care retirement community may be collected only after issuance of a cancelable priority reservation agreement to the person paying the fee, which agreement shall contain the following information:

a. the name and location of the community;

b. the name and address of the operator;

c. the name, address and phone number of a contact person;

d. the name and address of the person paying the fee;

e. the name and address of the escrow agent;

f. the type of unit being reserved;

g. the current entry fee and monthly care fee, together with a statement explaining that these fees are subject to change and may be changed by the time the prospective resident enters into a continuing care retirement contract with the operator;

h. the amount of any non-refundable priority reservation agreement application fee;

i. a notice in bold twelve point type that the cancelable priority reservation agreement does not obligate the person entering into the agreement in any way; that there is no guarantee by the operator that the current fees set forth in the agreement will not change; that the person paying the priority reservation fee may receive a refund of the fee plus interest accrued at prevailing rates upon request; and that he or she shall be entitled on a priority basis to apply the priority reservation fee to an actual entrance fee or entrance fee deposit on a unit not already under contract;

j. the signature of the person paying the fee and the signature of the operator or the operator's agent; and

k. a statement that the effective period of the agreement shall not exceed the duration of the commissioner's authorization.

6. a. In order to approve an application under this section, the commissioner shall have determined that:

(i) the operator has satisfied the requirements of this section and any applicable regulations; and

(ii) the operator can be expected to meet its obligations in accordance with this section and in accordance with its priority reservation agreements with prospective residents.

b. If the commissioner approves an application, the commissioner shall issue a written authorization to the operator authorizing the operator to enter into cancelable priority reservation agreements and collect refundable priority reservation fees from prospective residents concerning the continuing care retirement community.

c. The commissioner's authorization shall remain in effect as long as the operator's certificate of authority for its community remains in effect; provided that the commissioner may rescind the authorization at

any time for just cause, including any material misstatement of fact or misrepresentation in any of the application materials or any materials subsequently disseminated.

d. The operator shall provide written notice to all parties who have entered into cancelable priority reservation agreements of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements.

e. The commissioner shall provide written notice to the escrow agent of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements, including instructions to release funds held in escrow to the persons who have paid refundable priority reservation fees.

§ 4623. Long term care insurance and continuing care retirement contracts or continuing care at home contracts. 1. The commissioner may approve an application for a certificate of authority and may issue a certificate of authority for the establishment and operation of a continuing care retirement community under an arrangement which otherwise complies with the requirements of this article except that the costs of nursing facility or home health care services are paid for in whole or in part by (a) long term care insurance obtained and paid for by the resident or by medical assistance payments in accordance with the partnership for long term care program pursuant to section three hundred sixty-seven-f of the social services law and section three thousand two hundred twenty-nine of the insurance law or (b) other group or individual long term care insurance approved by the superintendent in connection with the application. The commissioner, in consultation with the superintendent, shall provide for adequate disclosure to residents of their options, rights and obligations under such an arrangement, and shall establish standards for the remittance and collection of premiums and monthly care fees.

2. With regard to nursing facility or home health care services which are part of the continuing care retirement contract or continuing care

at home contract, any elimination or waiting periods and any deductibles, copayments, or other amounts not paid for by such long term care insurance or medical assistance payments shall be the responsibility of the continuing care retirement community. The resident shall not be liable to pay any such amounts.

3. The continuing care retirement community operator shall not require that long term care insurance be purchased from a specified insurer or group of insurers and the operator shall not, without the approval of the council and the approval of the superintendent, specify a minimum acceptable benefit level different from that established under the partnership for long term care program.

4. Entrance fees and monthly care fees shall reflect that the cost of a resident's nursing facility and home health care services are or will be paid for in whole or in part in accordance with (a) the partnership for long term care program or (b) other group or individual long term care insurance approved by the superintendent and the council in connection with the application.

5. a. If a resident fails to maintain minimum long term care insurance coverage in accordance with this section, the continuing care retirement community operator shall purchase, if possible, such coverage on behalf of and at the expense of the resident and may require an appropriate adjustment in payments by the resident to the operator.

b. If the continuing care retirement community operator cannot purchase long term care insurance coverage under paragraph a of this subdivision, the operator may require an adjustment in the resident's monthly fees, subject to the approval of the superintendent, to fund the additional risk to the facility.

c. If the resident fails to maintain long term care insurance coverage in accordance with this section and the community operator has not purchased such coverage, the operator shall be responsible for any expenses which would have been covered under the long term care insurance policy which the resident failed to maintain. The operator may

add the amount of such expenses to the resident's monthly fees.

§ 4624. Continuing care retirement communities making assurances regarding long term care. 1. Nothing in this article shall obligate a continuing care retirement community to offer life care contracts; provided, however, that only continuing care retirement communities which offer life care contracts or which comply with the requirements set forth in subdivision two of this section shall be eligible for the following:

a. An exemption from a public need determination and establishment approval regarding an on-site or affiliated residential health care facility in accordance with subdivision five of section forty-six hundred four of this article; and

b. Industrial development agency financing in accordance with section forty-six hundred four-a of this article; or

c. Financing by any public benefit corporation authorized to make loans to continuing care retirement communities under the laws of this state.

2. A continuing care retirement community not exclusively offering life care contracts but desiring eligibility for an exemption from a public need determination and establishment approval and/or for industrial development agency financing or financing by any public benefit corporation authorized to make loans to continuing care retirement communities under the laws of this state must assure that all residents and prospective residents have the ability to fund the estimated cost of nursing facility services for a period of one year. Such assurances may be demonstrated through the terms of the continuing care contract, resident assets, resident income, long term care insurance or refund of all, or a portion of, the entrance fee and shall be in accordance with regulations adopted by the council. The community must pay for such care in the event that resident assets are insufficient to fund the cost of nursing facility care for a one year

period.

ARTICLE 46-A

FEE-FOR-SERVICE CONTINUING CARE

RETIREMENT COMMUNITIES DEMONSTRATION PROGRAM

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* **§ 4650. Short title.** This article shall be known and may be cited as the "Fee-for-service continuing care retirement community act".

* NB There are 2 § 4650's

* **§ 4651. Definitions.** As used in this article:

2. "Certificates" or "certificate of authority" shall mean an authorization in writing, approved and issued by the commissioner, for an operator to operate a fee-for-service continuing care retirement community and to enter into fee-for-service continuing care contracts pertaining to such community.

3. "Community" shall mean a fee-for-service continuing care retirement community established pursuant to this article.

4. "Control", "controlling", "controlled by", and "under common control with" shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities or voting rights, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of his or her being an officer or director of such other person. Control shall be presumed to exist if any person directly or indirectly owns, controls or holds with the power to vote ten percent or more of the voting securities or voting rights of any other person or is a corporate member of the legal entity.

5. "Council" shall mean the continuing care retirement community council, established pursuant to section forty-six hundred two of this chapter.

6. "Entrance fee" shall mean an initial or deferred transfer to an

operator of a sum of money, made or promised to be made by a person or persons entering into a fee-for-service continuing care contract, for the purpose of ensuring services pursuant to such a contract.

7. "Facility" shall mean any place in which an operator undertakes to provide a resident with the services of a fee-for-service continuing care retirement community, pursuant to a contract, whether such place is constructed, owned, leased, rented or otherwise contracted for by the operator.

8. a. "Fee-for-service continuing care retirement community" shall mean a facility or facilities established pursuant to this article to provide a comprehensive, cohesive living arrangement for the elderly, oriented to the enhancement of the quality of life, pursuant to the terms of the fee-for-service continuing care contract on a fee-for-service schedule. Such facility, at a minimum, shall provide access to on-site geriatric services, including, but not limited to, nursing facility services, services provided by an adult care facility, home health services, a meal plan, social services and independent living units.

b. "On-site" shall mean that, unless the context clearly requires otherwise, the services specified in paragraph a of this subdivision be provided at the facility.

9. "Fee-for-service continuing care contract" shall mean a single continuing care retirement contract that provides long-term care and other services on a per diem, fee-for-service or other agreed upon rate.

10. "Living unit" shall mean an apartment, room, cottage or other area within a community set aside for the exclusive use of one or more residents.

11. "Meal plan" shall mean an arrangement whereby the person entering into a fee-for-service continuing care contract is provided with no fewer than five meals per month. Additional meals shall be available on a fee-for-service basis.

12. "Monthly care fee" shall mean the monthly cost to a resident for prepayment of any services, including rent, rendered pursuant to a contract, exclusive of entrance fees or other prepayments, and any other regular periodic charges to the resident, determined on a monthly basis, pursuant to the provisions of a contract.

13. "Operator" shall mean a legal entity operating a fee-for-service continuing care retirement community pursuant to a certificate of authority, as granted pursuant to section forty-six hundred fifty-six of this article.

14. "Priority reservation agreement" shall mean a cancelable agreement between a prospective fee-for-service continuing care retirement community applicant, an applicant for a certificate of authority or an operator and a prospective resident, for the purpose of evaluating market demand for a proposed fee-for-service continuing care retirement community and for the purpose of guaranteeing to prospective residents an opportunity for priority placement in a fee-for-service continuing care retirement community, under which the prospective resident will pay a refundable priority reservation fee. A priority reservation agreement shall not be deemed to be a fee-for-service continuing care contract.

15. "Priority reservation fee" shall mean the refundable sum of money paid by a prospective resident for deposit with the escrow agent for a prospective fee-for-service continuing care retirement community applicant, an applicant for a certificate of authority or an operator pursuant to a priority reservation agreement.

17. "Resident" shall mean any person who, pursuant to a contract, is entitled to reside in and receive services from a fee-for-service continuing care retirement community.

18. "Social services" shall mean those services which may include, but are not limited to counseling, case management, and information and referral.

* NB There are 2 § 4651's

*** § 4652. Commissioner; powers and duties.** For the purposes of this article, the commissioner shall have all the powers and duties delegated to him or her pursuant to section forty-six hundred three of this chapter.

* NB There are 2 § 4652's

*** § 4653. Continuing care retirement community council; powers and duties.** For the purposes of this article, the council shall have all the powers and duties delegated to its members pursuant to section forty-six hundred two of this chapter; provided, however, that any references in such section to provisions of article forty-six of this chapter shall be deemed to be references to the corresponding provisions of this article.

* NB There are 2 § 4653's

§ 4654. Authorization of fee-for-service continuing care retirement communities. The commissioner shall approve up to eight fee-for-service continuing care retirement communities to encourage affordable care options for middle income seniors, up to two of which may be operated by a for-profit entity.

* NB There are 2 § 4654's

*** § 4655. Certificate of authority required; application and approval.**

1. No person shall construct, expand, acquire, maintain, or operate a fee-for-service continuing care retirement community, or enter into a contract as an operator, or solicit the execution of any contract for fee-for-service continuing care retirement community services to be provided within the state or advertise itself or otherwise hold itself as a "fee-for-service continuing care retirement community", without obtaining a certificate of authority pursuant to this article; provided, however, nothing in this subdivision shall prohibit a person, authorized pursuant to section forty-six hundred seventy-four or forty-six hundred seventy-five of this article, from entering into priority reservation

agreements, soliciting, collecting or receiving priority reservation fees, or constructing and maintaining sales offices and model units with respect to a proposed fee-for-service continuing care retirement community. Such facility shall obtain approval to utilize residential health care facility beds authorized under subdivision five of section forty-six hundred four of this chapter and/or shall meet such other conditions for acquisition of the residential health care facility beds as the commissioner may determine.

2. In order to receive a certificate of authority to enter into contracts with respect to a particular community, a person or persons, hereinafter designated as the applicant, shall apply for a certificate of authority on forms prescribed by the commissioner and, in addition, shall submit the following:

a. a feasibility study, including a market analysis describing the characteristics of the population to be served;

b. an initial disclosure statement as provided pursuant to section forty-six hundred fifty-seven of this article;

c. a copy of the proposed forms of contracts to be entered into with residents of the community;

d. complete details of any agreements with a licensed insurer, including copies of proposed contracts, requiring the insurer to assume, wholly or in part, the cost of medical or health related services to be provided to a resident pursuant to a fee-for-service continuing care contract;

e. a copy of each of the basic organizational documents and agreements of the applicant of all participating entities;

f. a copy of the bylaws, rules and regulations, and internal governing documents of the applicant;

g. architectural program and sketches for the community;

h. the proposed community plan, including the number of independent living units, skilled nursing facility beds, adult care facility beds, if any, and a description of other social and health services provided by the community;

i. copies of such financial and personal disclosure information as required by the council for the applicant and members of the board, officers, and controlling persons of the proposed fee-for-service continuing care retirement community, including:

(i) information necessary for the determination by the council of character, competence and experience, where information adequate to make such determinations is not otherwise available to the council,

(ii) a list of continuing care retirement communities, fee-for-service continuing care retirement communities, adult care facilities and health care facilities owned or operated by the applicant, by any controlling persons of the applicant, or by entities with which the members of the applicant's board are affiliated; the address of each such facility; and the dates of ownership or operation of each such facility,

(iii) in the event that any such community or facility specified in this subdivision, while under the control or operation of the applicant, or any controlling person, has been subjected to a limitation, withdrawal, or refusal to grant accreditation by a recognized accreditation organization, because of failure to comply with standards governing the conduct and operation of the facility, information that describes the nature of the violation, the agency or body enforcing the standard (including its name and address), the steps taken by the facility to remedy the violation, and an indication of whether any accreditation has since been restored, and

(iv) a statement as to whether the applicant or any of its officers, directors, partners, managers or a principal, parent or subsidiary corporation:

(A) has been convicted of a crime or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgement if the criminal or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property,

(B) had a prior discharge in bankruptcy or was found insolvent in any

court action, or

(C) is or was subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, actions affecting a license to operate a hospital as defined by section twenty-eight hundred one of this chapter, or a facility required to be licensed or certified by the department. The statement shall set forth the court or agency, date of conviction or judgement, the penalty imposed or damages assessed, or the date, nature and issuer of the order;

j. information which describes the populations to be served; and

k. any other information as may be required by regulations adopted pursuant to this article.

3. Nothing in this article shall be construed to enlarge, diminish or modify: a social services district's otherwise valid recovery under section three hundred sixty-nine of the social services law, nor medical assistance eligibility under title eleven of article five of the social services law, nor applicable provisions of the estates, powers and trusts law. Except as otherwise provided in this article, the activities of fee-for-service continuing care retirement communities shall be subject to any other law governing such activities including but not limited to article twenty-eight of this chapter and article seven of the social services law and regulations promulgated thereunder; provided, however, that the provisions of paragraphs (d) and (e) of subdivision four of section twenty-eight hundred one-a and section twenty-eight hundred two of this chapter shall not apply, and provided that the provisions of paragraph (a) of subdivision one and the provisions of subdivision two of section four hundred sixty-one-b of the social services law with respect to public need and the provisions of subdivision one of section four hundred sixty-one-c of the social services law shall not apply to residents who have been admitted in accordance with a fee-for-service continuing care contract provided that, upon admission to the adult care facility, such residents shall be

given a notice which shall include, at a minimum, information regarding facility services, resident responsibilities, supplemental services, resident rights and protections and circumstances that warrant transfer. The number of residential health care facility beds available pursuant to subdivision four of this section, without proof of public need therefor, shall be reduced by the number of residential health care demonstration facility beds that are approved pursuant to this article.

4. Up to three hundred fifty residential health care facility beds, as authorized in article forty-six of this chapter, that may be approved as components of fee-for-service continuing care retirement communities shall not be considered by the department and the health systems agencies in the determination of public need for residential health care facility services.

4-a. No certificate of authority shall be issued unless an application meeting the requirements of this section and all other requirements established by law has been approved by:

a. the commissioner as to the financial feasibility of the facility and the form and content of the proposed contracts to be entered into with residents;

b. the commissioner as to those aspects of the application relating to adult care facility beds, if any;

c. the public health council under section twenty-eight hundred one-a of this chapter as to the establishment of a skilled nursing facility by the applicant and as to such other facilities and services as may require the public health council's approval of the application; provided, however, that the recommendations of the state hospital review and planning council and the health systems agency having geographical jurisdiction of the area where the fee-for-service continuing care retirement community is located shall not be required with respect to the establishment of an on-site or affiliated residential health care facility to serve residents as part of the fee-for-service continuing care retirement community, for up to the total number of residential

health care facility beds provided for in subdivision four of this section in communities statewide;

d. the commissioner under section twenty-eight hundred two of this chapter; provided, however, that, the recommendations of the state hospital review and planning council and the health systems agency having geographical jurisdiction of the area where the fee-for-service continuing care retirement community is located shall not be required with respect to the construction of an on-site or affiliated residential health care facility to serve residents as part of the fee-for-service continuing care retirement community, for up to the total number of residential health care facility beds provided for in subdivision four of this section in communities statewide; and

e. the attorney general as to those aspects of the application relating to a cooperative, condominium or other equity arrangement for the independent living unit, if any.

4-b. The applicant shall agree to notify the commissioner at least sixty days in advance of any change in the rates to be charged to a resident by the operator for any entrance fee, monthly care fee and/or any separate charges for the housing component including, but not limited to, cooperative or condominium fees.

5. If the approvals required by subdivision four-a of this section have been obtained, the commissioner shall either approve or reject the application. In order to approve the application, the commissioner shall have determined that:

a. the proposed fee-for-service continuing care retirement community will meet a need and will fulfill the purposes of this article;

b. the applicant has satisfied the requirements of this article;

c. the applicant has demonstrated to the satisfaction of the council that the applicant and members of the board, officers, and controlling persons of the applicant, are of such character, experience, competence

and standing in the community as to give reasonable assurance of their ability to conduct the affairs of the proposed fee-for-service continuing care retirement community in the best interest of the community and in the public interest, and to provide proper care to residents. In the case of an applicant that is controlled, the council must be satisfied that the controlling person has also acted in a manner that is consistent with the public interest;

d. the applicant has otherwise demonstrated the capability to organize, market, manage, promote and operate the community and can be expected to meet its obligations in accordance with this article and in accordance with its contracts with residents;

e. the applicant has demonstrated that the total number of beds for the nursing facility component and the adult care facility bears a reasonable relation to the number of independent living units proposed for such community; and

f. with respect to communities which include a residential health care facility which does not require establishment approval under section twenty-eight hundred one-a of this chapter, the applicant has sufficient financial resources and sources of future revenues for the operation of the residential health care facility component.

6. Any change in the legal entity operating the fee-for-service continuing care retirement community, or in a controlling person of the community shall require approval in the same manner as an original application; provided, however, that the commissioner may waive any requirement to provide information that is not relevant to such change and provided, further, that the continued public need for the community shall be presumed.

7. The operator shall designate and make knowledgeable personnel available to prospective residents to answer questions about any information contained in the disclosure statement or contract. The disclosure statement and the contract shall each state on the cover or top of the first page in bold twelve point print the following "This

matter involves a substantial financial investment and a legally binding contract. In evaluating the disclosure statement and the contract prior to any commitment, it is recommended that you consult with an attorney and financial advisor of your choice, if you so elect, who can review these documents with you."

8. The commissioner shall issue a certificate of authority to the applicant upon approval of the application.

* NB There are 2 § 4655's

*** § 4656. Certificate of authority; authority of operator.** 1. A certificate of authority shall authorize an operator:

a. to operate a fee-for-service continuing care retirement community and to enter into contracts pertaining to such community;

b. to prepare and make public information that details the terms of any contract relating to a community;

c. to advertise the community and the related services that will be provided pursuant to this article; and

d. to offer and execute contracts, including the collection of entrance fees and deposits pursuant to sections forty-six hundred fifty-nine, forty-six hundred seventy-four and forty-six hundred seventy-five of this article.

2. a. The commissioner, in consultation with the council, may authorize an operator of a community with an on-site or affiliated residential health care facility to provide, for a limited period, residential health care facility services to persons, who are not residents of the community, provided, however, that the operator shall not discriminate in the admission, retention or care of any such person because such person is or will be eligible for, or receives or will receive, medical assistance benefits pursuant to title eleven of article five of the social services law.

b. The commissioner, in consultation with the council, may authorize an operator of a community with an on-site or affiliated adult care facility to provide, for a limited period, adult care facility services to persons, who are not residents of the community, provided, however, that the operator shall not discriminate in the admission, retention or care of any such person because such person is or will be eligible for, or receives or will receive, medical assistance benefits pursuant to title eleven of article five of the social services law or supplemental security income benefits pursuant to title sixteen of the federal social security act and any additional state payments made under title six of article five of the social services law.

* NB There are 2 § 4656's

*** § 4657. Initial disclosure statement.** Prior to the execution of a contract, or before the transfer of any money, other than a refundable priority reservation fee or non-refundable priority reservation agreement application fee, to an operator by or on behalf of a prospective resident, whichever occurs first, the operator shall deliver to the person with whom the contract is to be entered into, or the person's legal representative, the most recent annual statement as required by section forty-six hundred fifty-eight of this article, and an initial disclosure statement which contains the following:

1. The information contained in the contract, unless a copy of such contract is attached to and made a part of the initial disclosure statement, together with full disclosure of the use of any fees and charges in connection with the contract, including entrance fees;

2. The information required in paragraph h and subparagraphs (ii), (iii) and (iv) of paragraph i of subdivision two of section forty-six hundred fifty-five of this article;

3. The name and business address of the provider and a statement of whether the provider is an individual, partnership, corporation, or other legal entity;

4. The name and address of any person whose name is required to be provided pursuant to subdivisions two and three of this section and any professional service, firm, association, foundation, trust, partnership, corporation, or any other business or legal entity in which such person has, or which has in such person, a ten percent or greater interest and which it is presently intended will or may provide goods, leases, or services to the provider of a value of five hundred dollars or more, within any year, including a description of the goods, leases or services and the probable or anticipated cost thereof to the provider;

5. If the facility is to be operated by a manager:

a. the identities of any other facilities managed by said individual or entity and a copy of the agreement currently in effect or to be entered into between the provider and the manager for the operation of the facility;

b. if the manager is incorporated or established and operated on a for-profit basis, the identity of all individuals or entities holding any ownership or beneficial interest in the manager, and fees or any other compensation anticipated to be paid by the provider to the manager for the operation of the facility; and

c. the method by which the manager was chosen to manage the facility and, if the manager was chosen because of a condition in a mortgage commitment to the provider, the identity of the mortgagee requiring the condition in the commitment;

6. A description of the proposed or existing facility, including the location, size and anticipated completion date, if not completed;

7. A statement as to whether the applicant was or is affiliated, or has a contractual relationship, with a religious, charitable, or other nonprofit organization, the extent of any such affiliation or contractual relationship, and the extent to which the nonprofit organization will be responsible for the financial and contractual

obligations of the applicant;

8. If the facility is already in operation or if the applicant operates one or more similar facilities within or outside of this state, a statement of the changes in the scope of or the rates for care or services provided, including tables showing the frequency and average dollar amount of each increase in periodic rates at each such facility for the previous five years or such shorter period as the facility may have been operated by the provider;

9. If the applicant is the subsidiary corporation or the affiliate of another corporation, a statement identifying the parent corporation or the other affiliate corporation, the primary activities of such parent, or other affiliate corporation, the interest in the applicant held by such parent or other affiliate corporation, and the extent to which the parent corporation will be responsible for the financial and contractual obligations of the subsidiary;

10. The most recent financial statement of the provider prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by an independent certified or public accountant, including a balance sheet as of the end of the provider's last fiscal year and income statements for the last two fiscal years, or such shorter period of time as the provider has been in operation;

11. If construction, lease, rental, or purchase of the facility has not yet been completed, a statement of the anticipated source and application of the funds to be used in such purchase, lease, rental, or construction, including but not limited to:

a. an estimate of the cost of purchasing, leasing, renting, constructing and equipping the facility, including, but not limited to, such related costs as financing expenses, legal expenses, land costs, occupancy development costs, and all other similar costs that the provider expects to incur or become obligated for prior to the commencement of occupancy;

b. an estimate of the total entrance fees to be received from residents upon completion of occupancy;

c. a description of any mortgage loan or the other long-term financing intended to be used for the financing of the facility, including the anticipated terms and costs of such financing;

d. an estimate of any funds which are anticipated to be necessary to fund start-up losses and to assure full performance of the obligations of the operator pursuant to fee-for-service continuing care contracts including, but not limited to, any reserves required pursuant to section forty-six hundred sixty-four of this article;

e. a projection of estimated income from fees and charges other than entrance fees, a description of individual rates anticipated to be charged, and the assumptions used for calculating the estimated occupancy rate of the facility;

f. a projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses and separate allowances, if any, the replacement of equipment and furnishings and any anticipated major structural repairs or additions;

g. identification of assets pledged as collateral for any purpose; and

h. an estimate of assets pledged as collateral for any purpose;

12. A statement indicating community residents who are enrolled in a health maintenance organization may have nursing facility benefits under both the health maintenance organization subscriber contract and the fee-for-service continuing care contract. Such statement shall also indicate that if the health maintenance organization and the community cannot reach an agreement on appropriate financial arrangements, then the resident may have to be admitted to a facility approved by the health maintenance organization in order to receive their Medicare benefit for nursing facility services under the health maintenance

organization subscriber contract;

13. The initial disclosure statement and marketing materials of a community must clearly include a description of the services offered as part of its contract, and must clearly differentiate among the various types of contracts which it offers;

14. In accordance with regulations promulgated by the commissioner, the operator shall prepare a standard information sheet for each approved fee-for-service continuing care retirement community, which must be approved by the department, distributed with the community's marketing materials and attached to the initial disclosure statement prepared in accordance with this section. The standard information sheet shall be prepared in plain language and in twelve point type and shall include, but shall not be limited to the following information:

a. a brief description of the community, including its name and location and amenities and services available;

b. the name, address, and telephone number of the operator and a contact person employed by the operator;

c. the number and types of independent living units, adult care facility units and nursing home beds and whether such beds are on-site or off-site;

d. the types of contracts available;

e. a listing of all fees, charges, and refund options and the services covered by such fees and charges;

f. any insurance coverage required of residents; and

g. any other information which the council determines will assist a consumer in comparing the benefits and costs of different continuing care retirement communities and fee-for-service continuing care retirement communities; and

15. Any other information as may be required by regulations promulgated by the commissioner.

* NB There are 2 § 4657's

* **§ 4658. Annual statement.** 1. Within four months of close of an operator's fiscal year, unless an extension of time to file has been granted, the operator shall file an annual statement with the commissioner showing the condition as of the last day of the preceding calendar or fiscal year. If the commissioner does not receive the annual statement within four months of the end of the operator's fiscal year or has not granted an extension of time to file, the commissioner may charge a late fee.

2. The annual statement shall be in such form as the commissioner prescribes and shall contain at least the following:

a. Any change in status with respect to the information required to be submitted pursuant to section forty-six hundred fifty-seven of this article;

b. Financial statements audited by an independent certified public accountant, which shall contain, for two or more periods if the community has been in existence that long, the following:

(i) notes to the financial statements considered customary or necessary to ensure full disclosure of the financial statements, financial condition, and operation; and

(ii) an accountant's opinion and, in accordance with generally accepted accounting principles: (A) a balance sheet, (B) a statement of income and expenses, (C) a statement of equity or fund balances, and (D) a statement of changes in financial position;

c. A detailed listing of the assets maintained for the reserves; and

d. Such other reasonable financial and other information as the commissioner may require with respect to the operator or the community,

or its directors, controlling persons, trustees, members, branches, subsidiaries or affiliates to determine the financial status of the community and the management capabilities of the operator.

3. Sixty days before commencement of each calendar or fiscal year or official opening date, whichever is applicable, each operator shall file with the commissioner a computation of the annual long-term debt service and a projected annual revenue and expense summary for the next ten years.

* NB There are 2 § 4658's

*** § 4659. Fee-for-service continuing care contract.** A fee-for-service continuing care contract shall contain all of the following information in no less than twelve point type and in plain language, in addition to any other terms or matter as may be required by regulations issued by the commissioner:

1. The amount of all money transferred, including, but not limited to, donations, subscriptions, deposits, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents;

2. A description of all services which are to be furnished by the operator, a description of any fees in addition to the entrance fee and periodic charges provided for in the contract, and the conditions under which the fees may be adjusted, provided that an operator shall not charge any non-refundable application fee to a prospective resident who has paid a non-refundable priority reservation agreement application fee;

3. The procedures of the community relating to a resident's failure to pay the required monthly fees;

4. A statement of the figures and terms concerning the entry of a spouse to the community and the consequences if the spouse does not meet the requirements for entry;

5. A statement of the terms and conditions under which a contract may be canceled by the operator or by a resident and the conditions under which all or any portion of the entrance fee will be refunded by the operator, including the mandatory refund provisions set forth in sections forty-six hundred sixty and forty-six hundred sixty-two of this article;

6. The procedures and conditions under which a resident may be transferred from his or her living unit including a statement that, at the time of transfer, the resident will be given the reasons for the transfer; the process by which a transfer decision is made; the persons with the authority to make the decision to transfer; a description of any change in charges to be paid by the resident for services not covered by the contract fees as a result of the transfer; and a statement regarding the disposition of and the right to return to the living unit in cases of temporary and permanent transfers;

7. A statement that, if the resident dies prior to occupancy date or, through illness, injury or incapacity is precluded from becoming a resident under the terms of the contract, the contract is automatically rescinded and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except for those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by the parties to the contract;

8. A statement of the conditions under which all or any portion of the entrance fee will be released to the operator before the living unit becomes available for occupancy, and a statement of the conditions under which all or any portion of that fee will be refunded in the event of the death of the resident and/or spouse following occupancy of a living unit, including the mandatory refund provisions set forth in section forty-six hundred sixty of this article;

9. A statement of the advance notice to be provided the resident, of not less than sixty days, of any change in fees or charges or scope of care or services;

10. A statement that no act, agreement, or statement of any resident, or of an individual purchasing care for a resident under any agreement to furnish care to the resident, shall constitute a valid waiver of any provision of this article or of any regulation enacted pursuant thereto intended for the benefit or protection of the resident or the individual purchasing care for the resident;

11. A description of the reinstatement policies if a resident leaves the facility or the contract is canceled;

12. A statement that internal procedures to resolve disputes and grievances have been established, and residents notified of them;

13. A statement of the grace period, if any, for the payment of periodic fees without a penalty, and the extent of any penalty for the late payment thereof;

14. A statement that any amendment to the contract and any change in fees or charges, other than those within the guidelines of an approved rating system, must be approved by the commissioner;

15. A statement that property shall not be substituted as payment for either the entrance fee or monthly fee; and

16. A statement whether the fee-for-service continuing care contract includes any ownership, beneficial or trust interest in the assets of the operator, the assets of the facility, or both. Assets shall include, but are not limited to, property, trusts, reserves, interest and other assets.

* NB There are 2 § 4659's

*** § 4660. Withdrawal, death or dismissal of person; refund.** 1. Upon the giving of written notice of cancellation by certified mail of at least thirty days, the contract may be canceled by a resident for any reason, or by an operator if the applicant has willfully mismanaged

assets needed to pay monthly care fees. A resident shall not be discharged for inability to pay the monthly fee except where a showing of the willful mismanagement of assets needed to pay monthly care fees has been made.

2. If the notice required by subdivision one of this section is given within the first ninety days of occupancy, the resident shall receive a refund of not less than the entry fee and any other pre-payments less the actual cost of any services actually provided and the actual cost of refurbishing the unit for resale. After the first ninety days of occupancy, any refund shall be not less than the entrance fee, except that the operator may retain no more than two percent per month of occupancy by the resident of such fee and no more than a four percent fee for processing.

3. Refunds upon death will be made on the same basis as refunds upon withdrawal.

4. Any refund made pursuant to this section shall be paid no later than thirty days after the formerly occupied unit has been resold, but in no event later than one year after the formerly occupied unit has been vacated.

* NB There are 2 § 4660's

* **§ 4661. Consumer safeguards.** The applicant shall demonstrate the financial feasibility of the facility. The operator shall provide a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

1. An estimate of the cost of purchasing or constructing and equipping the facility, which includes related costs such as financing expenses, legal expenses, land costs, marketing and development costs and other similar cost the provider expects to incur or become obligated for prior to the commencement of operations;

2. A description of any mortgage loan or other long-term financing

intended to be used for the financing of the facility and the anticipated terms and costs of financing;

3. An estimate of the total amount of entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility;

4. An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses, and provide reserve funds to assure full performance of the obligations of the provider under contracts for the provision of continuing care;

5. A projection of estimated income from fees and charges other than entrance fees, a description of individual rates anticipated to be charged, the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of government subsidies, if any, for health care services provided pursuant to the contracts for fee-for-service continuing care;

6. A projection of estimated operating expenses of the facility, including a description of the assumptions used in calculating the expenses and separate allowances, if any, the replacement of equipment and furnishings and any anticipated major structural repairs or additions;

7. Identification of assets pledged as collateral for any purpose;

8. An estimate of annual payments or principal and interest required by any mortgage loan or other long-term financing; and

9. Such other material information concerning the facility or the operator as required by the commissioner or as agreed upon by the operator and the prospective resident.

* NB There are 2 § 4661's

* **§ 4662. Entrance fee escrow account.** As a condition for approval to

advertise and collect refundable entry fees/deposits:

1. The operator shall establish an interest-bearing account with a New York state bank, New York state savings and loan association, or New York state trust company for any entrance fees received by the operator, which escrow funds shall be subject to release as provided by section forty-six hundred sixty-three of this article.

2. An escrow agreement shall be entered into between the bank, savings and loan association, or trust company and the operator of the community. The agreement shall state that its purpose is to protect the resident or the prospective resident and that, upon presentation of evidence of compliance with applicable portions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the operator or resident as directed.

3. Checks, drafts and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

4. All funds deposited in the escrow account shall remain the property of the resident until released to the operator in accordance with section forty-six hundred sixty-three of this article, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditor's claims against the operator or community.

5. At the request of the operator or the commissioner, the escrow agent shall issue a statement indicating the status of the escrow account.

6. If the funds in an escrow account under this section and any interest thereon are not released to the operator within such time as provided by rules and regulations adopted by the council, then such funds shall be returned by the escrow agent to the persons who had made payment to the operator.

7. An entrance fee held in escrow may be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the operator that such person is entitled to a refund of the entrance fee.

8. Nothing in this section shall be interpreted as requiring the escrow of any nonrefundable application fee, designated as such in the contract, received by the operator from a prospective resident.

9. Occupancy of housing or other facilities shall not begin until:

a. the operator has executed contracts accompanied by a deposit of at least ten percent of the entry fee payment for fifty percent of all units or an approved phase of a community; and

b. all permits and approvals necessary for operation of the community, or an approved phase of a community, have been granted except those depending upon construction; provided, nothing in this subdivision shall prohibit an operator, upon the approval of the council, or an applicant or prospective applicant upon the approval of the commissioner pursuant to section forty-six hundred seventy-four of this article, from constructing model units and a sales office.

10. Any entry fee deposit required by an operator shall be fully refundable if the contract is canceled within seventy-two hours of its execution. In the event of cancellation, the entry fee deposit shall be refunded within three business days of receipt of cancellation.

* NB There are 2 § 4662's

*** § 4663. Release of escrowed funds to the operator.** Escrowed funds shall not be released to the operator unless:

1. construction or purchase of the community or an approved phase of a community has been substantially completed, an occupancy permit covering the living unit has been issued by the local government having authority

to issue such permits, and the living unit becomes available for occupancy; or

1-a. the operator has submitted an application to the commissioner, on forms approved by the department, for authorization to use escrowed entrance fees to assist the operator in financing the construction or purchase of a proposed community, and the commissioner, in accordance with such regulations as may be promulgated by the council, has approved such application. The commissioner shall not approve such application unless satisfied that the following conditions have been met:

a. the operator has executed contracts accompanied by an entrance fee or entrance fee deposit for at least seventy percent of all proposed living units or an approved phase of a community;

b. the aggregate entrance fees or deposits received or receivable by the operator pursuant to executed fee for service continuing care contracts equal at least ten percent of the total of the entrance fees due at occupancy for at least seventy percent of all proposed living units or an approved phase of a community;

c. the operator has entered into a contract for the construction or purchase of the community which contract has a fixed maximum price and, if a construction contract, the contractor has secured a performance or completion bond for the benefit of the operator;

d. the operator has received a firm commitment for a permanent mortgage loan or other long term financing and conditions to the commitment prior to disbursement of funds thereunder, other than completion of construction or purchase, are substantially satisfied;

e. the total amount of escrowed entrance fees or deposits that may be approved for release under this subdivision shall not exceed fifteen percent of the total costs of acquiring, constructing and equipping the proposed community;

f. use of the entrance fees or deposits shall not impair the

operator's ability to comply with the requirements of section forty-six hundred sixty-four of this article;

g. the operator's executed contracts or amended contracts referred to in paragraph a of this subdivision, and all contracts generating the entrance fees for which release is sought, contain a provision conspicuously disclosing the intended use of entrance fees, and that all refunds shall be in accordance with the otherwise applicable provisions of this article, the regulations adopted pursuant thereto and the contract;

h. the use of the entrance fees or deposits under this subdivision will promote the efficient and cost-effective acquisition or development of the proposed community; and

i. the release, availability and use of the entrance fees comply with any other conditions the council shall establish.

2. if the entrance fee gives the resident the right to occupy a living unit which has been previously occupied, the entrance fee and any interest earned thereon shall be released to the operator when the living unit becomes available for occupancy by the new resident; or

3. if the entrance fee applies to a living unit which has not been previously occupied, the entrance fee and any interest earned thereon shall be released to the operator when the commissioner is satisfied that:

a. Aggregate entrance fees received or receivable by the operator pursuant to executed fee-for-service continuing care contracts equal at least ten percent of the total of the entrance fees due at occupancy for at least seventy percent of all proposed living units or an approved phase of a community.

b. In lieu of any escrow required pursuant to this article, an operator is entitled to post a letter of credit from a financial institution, negotiable securities or a bond by a surety authorized to

do business in this state, in a form approved by the commissioner and in an amount not to exceed the amount established in paragraph a of this subdivision. The operator shall execute the letter of credit, negotiable securities or bond in favor of the commissioner on behalf of individuals who are entitled to a refund of entrance fees from the provider.

* NB There are 2 § 4663's

§ 4664. Asset reserves. An operator shall maintain reserve liabilities and supporting assets in an amount for the purposes set forth in a regulation issued by the commissioner. Liquid assets shall be maintained for the following reserve liabilities:

1. Fifteen percent of the projected annual operating expenses of the facility, exclusive of depreciation.

2. A provider shall notify the commissioner in writing at least ten days prior to reducing the amount of funds available to satisfy the applicable liquid reserve requirement. A provider shall not expend more than one-half of the required balance each calendar year.

3. A provider may use funds in an endowment fund or escrow account, including an escrow account established by or pursuant to a mortgage loan, bond, indenture or other long-term financing, to satisfy the reserve requirements of this section, if the funds are available to make payments when operating funds are insufficient for these purposes.

§ 4665. Residents' organizations. 1. Residents living in a community authorized by this article shall have the right of self-organization, the right to be represented by one or more individuals of their own choosing, and the right to engage in concerted activities for the purpose of keeping informed of the operation of the community in which they live.

2. The board of directors, a designated representative, or other such governing body of a fee-for-service continuing care retirement community

shall meet at least four times a year with residents' representatives and shall hold a general meeting of all residents once a year for the purpose of discussing subjects including, but not limited to, the financial position of the community, the quality of social and health services at the community, and any proposed changes in policies, programs or services.

§ 4666. Advertisements. No person, partnership, corporation, company, trust or association, or any agent or employee thereof, shall publish or cause to be published, circulated, or disseminated any financial statement, pamphlet, circular, form letter, advertisement, or other sales literature or advertising communication addressed or intended for distribution to prospective residents of fee-for-service continuing care retirement communities that contains statements or illustrations that are untrue, deceptive, misleading, or omit material facts or omit any other information required by regulations appropriate to a fee-for-service continuing care retirement community.

§ 4667. Audits. 1. The commissioner, or his or her designee, may at any time, and shall at least once every three years, visit each community and examine the business of any applicant for a certificate of authority and any operator engaged in the execution of fee-for-service continuing care contracts or engaged in the performance of obligations under such contracts. Routine examinations may be conducted by having documents designated by and submitted to the commissioner, which shall include financial documents and records conforming to commonly accepted accounting principles and practices. The final written report of each such examination conducted by the commissioner shall be filed with the commissioner and, when so filed, shall constitute a public record. A copy of each report shall be provided to members of the continuing care retirement community council. Any operator being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the commissioner may, at any time, examine the records and affairs and inspect the community's facilities, whether in connection with a formal examination or not.

2. Any duly authorized officer, employee, or agent of the department may, upon presentation of proper identification, have access to and inspect, any records maintained by the community relevant to the department's regulatory authority, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this article.

3. Reports of the results of such examinations and inspections shall be kept on file by the commissioner and shall be open to public inspection at the community, provided any records, reports or documents which by state or federal law or regulation are deemed confidential shall not be distributed or made available unless and until such confidential status has expired.

§ 4668. Revocation, suspension or annulment of certificate of authority. 1. The commissioner may revoke, suspend, limit or annul the certificate of authority of an operator upon proof that:

a. The operator failed to continue to meet the requirements for the authority originally granted;

b. The operator lacked one or more of the qualifications for the certificate of authority as specified by this article;

c. The operator made a material misstatement, misrepresentation, or committed fraud in obtaining the certificate of authority, or in attempting to obtain the same;

d. The operator lacked fitness or was untrustworthy;

e. The operator engaged in fraudulent or dishonest practices of management in the conduct of business under the certificate of authority;

f. The operator converted or withheld funds;

g. The operator failed to comply with, or violated, any proper order, rule or regulation, or violated any provision of this article;

h. The unsound business practices of the operator renders its further transactions in this state hazardous or injurious to the public;

i. The operator has refused to be examined or to produce its accounts, records and files for examination, or its officers, employees or controlling persons have refused to give information with respect to the affairs of the community or to perform any other legal obligation as to such examination; or

j. The commissioner has found violations of applicable statutes, rules or regulations which threaten to affect directly the health, safety, or welfare of a resident of a fee-for-service continuing care retirement community.

2. No certificate of authority shall be revoked, suspended, limited or annulled without a hearing, except that a certificate of authority may be temporarily suspended or limited prior to a hearing for a period not in excess of sixty days upon written notice to the operator following a finding by the commissioner that public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices that pose an imminent danger to the health or safety of any resident. Any delay in the hearing process occasioned by the operator shall toll the running of said suspension or limitation and shall not abridge the full time provided in this subdivision.

3. Any state agency which seeks to revoke, suspend, limit or annul the certificate of authority or any other license or certificate required to be obtained by an operator of a community pursuant to law, shall request the commissioner to commence a hearing pursuant to this section.

4. The commissioner shall fix a time and place for the hearing. The commissioner shall cause to be served in person or mailed by registered or certified mail to the operator at least ten days before the date

fixed for the hearing a copy of the charges, together with the notice of the time and place of the hearing. The operator shall file with the commissioner not less than three days prior to the hearing a written answer to the charges. The agency which initiated the proceeding shall be responsible for providing evidence in support of the charges to the commissioner in order to prepare a statement of charges and shall provide evidence in support of the charges at the hearing.

5. All orders pursuant to this section shall be subject to review as provided in article seventy-eight of the civil practice law and rules. Application for such review shall be made within sixty days after service in person or by registered or certified mail of a copy of the order upon the operator.

§ 4669. Appointment of a caretaker. Upon a determination by the commissioner that there exists operational deficiencies in a fee-for-service continuing care retirement community that show:

1. there exists in the facility a pattern or practice of habitual violation of the standards of health, safety or patient care established under federal or state law or regulations, the commissioner shall take the actions prescribed by section forty-six hundred sixty-eight of this article, and, where the commissioner deems it to be in the public interest, the commissioner shall petition a court of competent jurisdiction to appoint a caretaker as defined in section twenty-eight hundred one of this chapter. The petition, the proceedings, and the procedures for appointment of a caretaker shall be governed by the provisions of section forty-six hundred seventy of this article, and the power, duties and rights of a caretaker appointed pursuant to such section shall be the same as those authorized by subdivision four of such section; or

2. a condition or conditions in substantial violation of the standards for health, safety or patient care established under federal or state law or regulations.

§ 4670. Receiverships. 1. The commissioner may, upon a determination that serious operational deficiencies exist or serious financial problems exist and such action is desirable, enter into an agreement with the operator or owners of a fee-for-service continuing care retirement community with respect to the appointment of a receiver to take charge of the community under conditions as found acceptable by both parties. Receivership commenced in accordance with the provisions of this subdivision shall terminate at such time as may be provided in the receivership agreement, or at such time as either party notifies the other in writing that it wishes to terminate such receivership.

2. The commissioner shall, at the time of revocation, suspension or temporary suspension of a certificate of authority, apply to the supreme court where the community is situated for an order directing the owner of the land and/or structure on or in which the community is located, to show cause why a receiver should not be appointed to take charge of the community. In those cases where the certificate of authority has been revoked, suspended or temporarily suspended, the supreme court shall appoint a receiver that, where reasonably possible, is a legal entity that holds a valid certificate of authority. Such application shall contain proof by affidavit that the facility has had its certificate of authority revoked, suspended or temporarily suspended. Such order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy thereof and the papers on which it is based, on the owner or owners of the land and/or structures on or in which the community is located. If any such owner and manager cannot with due diligence be served personally within the county where the property is located and within the time fixed in such order, then service may be made on such person by posting a copy thereof in a conspicuous place within the community in question, and by sending a copy thereof by registered mail, return receipt requested, to such owner at the last address registered by such owner with the department or in the absence of such registration to the address set forth in the last recorded deed with respect to the facility. Service shall be deemed complete on filing proof of service thereof in the office of the county clerk, or the clerk of the city of New York, as the

case may be.

3. On the return of said order to show cause, the matter shall have precedence over every other business of the court unless the court shall find that some other pending proceeding, having a similar statutory precedence, shall have priority. The court may conduct a hearing at which all interested parties shall have the opportunity to present evidence pertaining to the application. If the court shall find the facts warrant the granting thereof, then any such qualified and approved agency, person or corporation, or the commissioner or any person designated by the commissioner, shall be appointed receiver to take charge and assume operation of the community. However, such receiver may make application to the appointing court for decision, reformation or such other relief as may be appropriate to protect the best interests of the residents residing within such community. No security interest in any real or personal property comprising the community shall be impaired or diminished in priority by the receiver. The receiver shall compensate the owner or owners of any goods held in inventory for those goods which he or she uses or causes to be used by reimbursing the costs of such goods, except that no such compensation shall be made for any goods for which the owners or operators of the community have already been reimbursed.

4. Any receiver appointed pursuant to this section shall have all of the powers and duties of a receiver appointed in an action to foreclose a mortgage on real property, together with such additional powers and duties as are granted and imposed pursuant to this section. The receiver may correct or eliminate those deficiencies in the facility that seriously endanger the life, health, safety or finances of such residents subject to such terms as the court may direct. The receiver shall operate the community in such a manner as intended to assure safety and adequate care for such residents. Any receiver who is an official or employee of the state shall not be required to file any bond. The receiver shall honor all existing leases, mortgages and chattel mortgages that had previously been undertaken as obligations of the owners or operators of the community.

5. The appointing court, upon application of the receiver, may make such provision as justice may require for reasonable compensation and reimbursement of the reasonable expenses of the receiver. The receiver shall be liable only in his or her official capacity for injury to person and property by reason of conditions of the community in a case where an owner would have been liable; provided that he or she operates such facility in compliance with the terms of his or her appointment, the receiver shall not have any liability in his or her personal capacity, except for gross negligence and intentional acts.

6. a. The court shall terminate the receivership only under the following circumstances:

- (i) when the community is issued a new certificate of authority; or
- (ii) at such time as all of the residents in the community have been provided alternate residential and health care services.

b. At the time of termination, the receiver shall render a full and complete accounting to the court and shall make disposition of surplus money at the discretion of the court.

7. a. Any person who is served a copy of an order of the court appointing the receiver shall, upon being notified of the name and address of the receiver, make all payments for goods supplied by the community, or services rendered by the community, to the receiver. A receipt shall be given for each such payment, and copies of all such receipts shall be kept on file by the receiver. The amount so received shall be deposited by the receiver in a special account which shall also be used for all disbursements made by the receiver.

b. Any person refusing or omitting to make such a payment after such service and notice may be sued therefor by the receiver. Such person shall not in such suit dispute the authority of the receiver to incur or order such expenses, or the right of the receiver to such payments made to him or her. The receipt provided by the receiver for any sum paid to him or her shall, in all suits and proceedings and for every other purpose, be as effectual in favor of any person holding the receipt as actual payment of the amount thereof to the operator or other person or

persons who would, but for the provisions of this section, have been entitled to receive the sum to be paid. No resident shall be discharged, nor shall any contract or rights be forfeited or impaired, nor any forfeiture or liability be incurred, by reason of any omission to pay any operator, owner, contractor or other person any sum so paid to the receiver.

8. Any other provision of this article notwithstanding, the commissioner may, if such commissioner deems appropriate, grant to any community operating or scheduled to operate under a receivership authorized by this section a certificate of authority, the duration of which shall be limited to the duration of the receivership.

9. a. No provision of this section shall be deemed to relieve the operator, owner or manager of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the operator, owner or manager prior to the appointment of any receiver pursuant to this section, nor shall anything in this section be construed to suspend during the receivership any obligation of the owner for the payment of taxes or other operating and maintenance expenses of the community nor of the owner or any other person for the payment of mortgages or liens.

b. The receiver shall not be responsible for any obligations incurred by the owner, manager or prime lessor, if any, prior to the appointment of the receiver, other than those obligations to residents pursuant to the fee-for-service continuing care contracts.

c. The receiver shall be entitled to use for operating and maintenance expenses and the basic needs of the residents of the community a portion of the revenues due the operator during the month in which the receiver is appointed, which portion shall be established on the basis of the amounts of the unpaid operating and maintenance expenses for such month.

§ 4671. Civil action. Any person who, as or on behalf of an operator, enters into a contract without having first delivered to the prospective

resident the disclosure statement and annual report required by sections forty-six hundred fifty-seven and forty-six hundred fifty-eight of this article; or delivers to the prospective resident a disclosure statement or annual report that omits a material fact or makes an untrue or misleading statement of material fact shall be liable to the individual contracting for services pursuant to such contract for damages and repayment of all entrance, application, periodic charge or other fees paid by such person, less the reasonable cost of care and housing provided until discovery of the violation or until the violation should reasonably have been discovered, together with interest, costs and reasonable attorney's fees.

§ 4672. Criminal penalties. 1. A person, partnership, corporation, controlling person, or agent or employee thereof, who knowingly uses or employs any act or practice in violation of this article shall be guilty of a class A misdemeanor.

2. Nothing under this article shall be deemed to limit the power of the state to punish any person for any conduct which also constitutes a separate crime under any other statute.

3. The council may refer such evidence as is available concerning violations of this article to the appropriate district attorney who may, with or without such reference, institute appropriate criminal proceedings.

§ 4673. Separability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this article directly involved in the controversy in which the judgment shall have been rendered.

§ 4674. Priority reservation agreements; prior to obtaining a certificate of authority. The provisions of this section shall apply to entities that seek approval to enter into priority reservation agreements and to solicit, collect or receive priority reservation fees, with respect to a proposed fee-for-service continuing care retirement community, prior to obtaining a certificate of authority under this article.

1. No person, partnership, corporation or other entity shall solicit, collect or receive any priority reservation fee or enter into any agreement relating to the payment of any priority reservation fee with respect to any fee-for-service continuing care retirement community to be operated within the state without first obtaining the written authorization of the commissioner. The commissioner shall not grant such authorization to an entity that has not yet obtained a certificate of authority unless the requirements of this section and any applicable regulations are met. Upon obtaining the authorization of the commissioner under this section, a prospective community applicant or an entity having filed an application for a certificate of authority may enter into cancelable priority reservation agreements with prospective residents and solicit, collect and receive refundable priority reservation fees for direct deposit into an escrow account, prior to obtaining a certificate of authority, for the purpose of evaluating market demand for a proposed fee-for-service continuing care retirement community and for the purpose of guaranteeing to prospective residents an opportunity for priority placement in a fee-for-service continuing care retirement community. A priority reservation fee shall not exceed two thousand dollars unless the commissioner, in the discretion of such commissioner, establishes that a priority reservation fee may exceed two thousand dollars. A non-refundable priority reservation agreement application fee shall not exceed the maximum amount established by the commissioner, in such commissioner's discretion.

2. In order to receive authorization by the commissioner to enter into cancelable priority reservation agreements and to solicit, collect or receive any refundable priority reservation fee, a person, partnership, corporation or other entity, hereinafter designated as the applicant,

shall apply for such authorization on forms or in a format prescribed by the commissioner and, as part of such application, shall submit the following information:

a. a description of the applicant's plan to implement the process of entering into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees;

b. a general description of the proposed community, including the location and description of the proposed community site; the components to be included in the community, such as independent living units, skilled nursing facility and adult care facility; the estimated number of each type of unit or beds; and the services to be provided;

c. an estimate of the pricing structure of the community including entrance fees and monthly care fees and the provisions of the fee-for-services rates;

d. a description of the anticipated market to be served;

e. anticipated methods and sources of financing for the proposed community;

f. organizational structure of the applicant;

g. the name and address of the escrow agent and a copy of the escrow agreement required pursuant to this section;

h. a copy of the instructions to the escrow agent regarding the issuance of refunds;

i. a copy of the forms to be used to document a request for a refund of a priority reservation fee and the issuance of such refund;

j. a copy of the most recent set of financial statements of the applicant prepared in accordance with generally accepted accounting principles and certified to be true and accurate by an independent

certified public accountant;

k. draft copies of all proposed marketing materials, including final marketing materials as soon as available; provided that the provision of such material shall not be construed to require approval of such materials by the department or the council;

l. a description of the sales office and a copy of the preliminary site plans and drawings of any proposed model units;

m. a copy of the proposed priority reservation agreement; and

n. any other information as may be required by regulations adopted pursuant to this article.

3. Any change in the legal entity authorized under this section to enter into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees shall require approval in the same manner as the original application; provided, however, that the commissioner may waive any requirement to provide information that is not relevant to such change.

4. a. As a condition to receiving the commissioner's authorization under this section, an applicant shall establish a government insured interest-bearing account, which earns interest at a rate which is consistent with prevailing interest rates, and enter into an escrow agreement with a New York state bank, New York state savings and loan association or New York state trust company for the deposit of any priority reservation fees collected by the applicant pursuant to this section, which escrow funds shall be subject to release as provided for in this section.

b. The escrow agreement shall state that its purpose is to protect prospective residents who have paid a priority reservation fee to the applicant in furtherance of the applicant's efforts to evaluate market demand for a proposed fee-for-service continuing care retirement community and to guarantee prospective residents an opportunity for

priority placement in a fee-for-service continuing care retirement community and that, upon presentation of evidence of compliance with applicable portions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the applicant, the prospective resident or the prospective resident's legal representative as directed, within fifteen business days of receipt of the notice by the escrow agent.

c. Checks, drafts and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

d. All funds deposited in the escrow account shall remain the property of the prospective residents until released to the applicant in accordance with this article, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments or creditors' claims against the applicant.

e. At the request of the applicant, the commissioner or a prospective resident, the escrow agent shall issue a statement indicating the status of the escrow account.

f. A prospective resident's escrowed funds shall not be released to an applicant unless the applicant obtains a certificate of authority to operate the proposed fee-for-service continuing care retirement community and to enter into fee-for-service continuing care contracts, and the prospective resident has entered into a fee-for-service continuing care contract with the applicant and has elected to apply the priority reservation fee to an actual entrance fee or deposit on an entrance fee. Upon release to the approved applicant, a prospective resident's escrowed priority reservation fee funds shall be deposited into the entrance fee escrow account provided for in section forty-six hundred sixty-two of this article.

g. If the funds in an escrow account under this section, and any interest thereon, are not released to the applicant within such time as

provided by rules and regulations adopted by the council, then such funds shall be returned by the escrow agent to the person who had made the payments or the person's legal representative.

h. A priority reservation fee, and the interest accrued thereon, held in escrow shall be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the applicant or the person who paid the fee or the person's legal representative that the priority reservation agreement has been canceled. Any priority reservation fee, and the interest accrued thereon, shall be returned by the escrow agent to the person who paid the fee or the person's legal representative within fifteen business days of receipt by the escrow agent of notice of cancellation of the priority reservation agreement.

i. Refunds of priority reservation fees upon the death of a prospective resident shall be made upon the same basis as refunds upon cancellation of a priority reservation agreement.

j. Nothing in this section shall be interpreted as requiring the escrow of any non-refundable priority reservation agreement application fee, designated as such in the cancelable priority reservation agreement, which fee is received by the applicant from a prospective resident.

5. Any marketing materials, including all materials associated with a sales office and model units, used in the solicitation of priority reservation agreements or priority reservation fees shall, at a minimum, contain the following:

a. a statement that the purpose of the marketing material is to determine the market demand for a proposed fee-for-service continuing care retirement community and to offer prospective residents an opportunity for a guaranteed priority placement in a fee-for-service continuing care retirement community by entering into cancelable priority reservation agreements and accepting refundable priority reservation fees;

b. a statement that the cancelable priority reservation agreement is not a fee-for-service continuing care contract and may be canceled by the person entering the agreement or the person's legal representative at any time, without cause; and

c. a statement that any priority reservation fees paid shall be held in escrow and shall be refunded, together with interest accrued at prevailing rates, to the person paying the fee or the person's legal representative upon request and cancellation of the priority reservation agreement.

6. Any priority reservation fees with respect to a proposed fee-for-service continuing care retirement community may be collected only after issuance of a cancelable priority reservation agreement to the person paying the fee, which agreement shall contain the following information:

a. the name and location of the proposed community;

b. the name and address of the applicant;

c. the name, address and phone number of a contact person;

d. the name and address of the person paying the fee;

e. the name and address of the escrow agent;

f. the type of unit being reserved;

g. the estimated entry fee and monthly care fee clearly identified as an estimate;

h. the amount of any non-refundable priority reservation agreement application fee;

i. a notice in bold twelve point type that the cancelable priority reservation agreement does not obligate the person entering into the

agreement in any way; that there is no guarantee by the applicant the fees estimated in the agreement will not change; that the community described is only a proposed community and any model units are only representative of units in a proposed community which is subject to the submission of a formal application by the applicant and the subsequent approval or disapproval by the council; that there is no guarantee the unit described in the agreement or represented by any model will be built or otherwise made available as described in the agreement or at all; that the person paying the priority reservation fee may receive a refund of the fee plus interest accrued at prevailing rates upon request; and that, should a certificate of authority be granted, he or she shall be entitled on a priority basis to apply the priority reservation fee to an actual entrance fee or entrance fee deposit on a unit not already under contract;

j. the signature of the person paying the fee and the signature of the applicant or the applicant's agent;

k. a statement of the effective period of the agreement not to exceed the duration of the commissioner's authorization; and

l. an outline of the fees, their associative service, and guidelines used for changing the residency status of a resident.

7. a. In order to approve an application under this section, the commissioner shall have determined, as applicable, that:

(i) the applicant has satisfied the requirements of this section and any applicable regulations; and

(ii) the applicant has demonstrated the capability to conduct a market analysis of the demand for the proposed fee-for-service continuing care retirement community and can be expected to meet its obligations in accordance with this section and in accordance with its priority reservation agreements with prospective residents.

b. If the commissioner approves an application, the commissioner shall issue a written authorization to the applicant authorizing the applicant to enter into cancelable priority reservation agreements and collect

refundable priority reservation fees from prospective residents concerning the proposed fee-for-service continuing care retirement community.

c. The commissioner's authorization shall remain in effect for a period not to exceed eighteen months from the date of the commissioner's authorization the commencement of said period to be specifically stated in such authorization subject to the following:

(i) the commissioner may rescind the authorization, including any extension thereof, at any time for just cause, including any material misstatement of fact or misrepresentation in any of the application materials or any materials subsequently disseminated;

(ii) the authorization may be extended upon written application to an approval of the commissioner for the duration of time specified in the commissioner's written approval;

(iii) unless already expired, the authorization shall be extended automatically if an application for a certificate of authority is submitted pursuant to this article, and such authorization shall remain in effect as long as the application for a certificate of authority remains active; and

(iv) unless already expired, the authorization shall be extended automatically if a certificate of authority is obtained by the applicant pursuant to this article, and such authorization shall remain in effect as long as the certificate of authority remains in effect.

d. The applicant shall provide written notice to all parties who have entered into cancelable priority reservation agreements of the following:

(i) notice of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements;

(ii) notice of the commissioner's extension of authorization to enter into cancelable priority reservation agreements including the new expiration date and the reason for such extension; and

(iii) notice upon issuance of a certificate of authority pursuant to this article that the party to the agreement has the option on a priority basis to apply the priority reservation fee to an actual entrance fee or a deposit on an entrance fee.

e. The commissioner shall provide written notice to the escrow agent of the commissioner's rescission of authorization to enter into cancelable priority reservation agreements, including instructions to release funds held in escrow to the persons who have paid refundable priority reservation fees.

§ 4675. Priority reservation agreements; after obtaining a certificate of authority. The provisions of this section apply to entities that seek approval to enter into priority reservation agreements and to solicit, collect or receive priority reservation fees, with respect to a fee-for-service continuing care retirement community, after obtaining a certificate of authority under this article.

1. No person, partnership, corporation or other entity shall solicit, collect or receive any priority reservation fee or enter into any agreement relating to the payment of any priority reservation fee with respect to any fee-for-service continuing care retirement community operated or to be operated within the state without first obtaining the written authorization of the commissioner. The commissioner shall not grant such authorization to an entity that has obtained a certificate of authority unless the requirements of this section and any applicable regulations are met. Upon obtaining the authorization of the commissioner under this section, an operator may enter into cancelable priority reservation agreements with prospective residents and solicit, collect and receive refundable priority reservation fees for direct deposit into an escrow account for the purpose of guaranteeing to prospective residents an opportunity for priority placement in the fee-for-service continuing care retirement community for which the operator has obtained a certificate of authority. A priority reservation fee shall not exceed two thousand dollars unless the commissioner, in the discretion of such commissioner, establishes that a priority reservation fee may exceed two thousand dollars. A non-refundable priority reservation agreement application fee shall not exceed the maximum amount established by the commissioner, in such commissioner's discretion.

2. In order to receive authorization by the commissioner to enter into cancelable priority reservation agreements and to solicit, collect or receive any refundable priority reservation fee, an operator shall apply for such authorization on forms or in a format prescribed by the commissioner and, as part of such application shall submit the following information:

a. a description of the applicant's plan to implement the process of entering into cancelable priority reservation agreements and to solicit, collect or receive refundable priority reservation fees;

b. the name and address of the escrow agent and a copy of the escrow agreement required pursuant to this section;

c. a copy of the instructions to the escrow agent regarding the issuance of refunds;

d. a copy of the forms to be used to document a request for a refund of a priority reservation fee and the issuance of such refund;

e. draft copies of all proposed marketing materials, provided that copies of the final marketing materials must be submitted as soon as they are available provided further that provision of such materials shall not be construed to require approval of such materials by the department or the council;

f. a description of the sales office and drawings of any proposed model units;

g. a copy of the proposed priority reservation agreement; and

h. any other information as may be required by regulations adopted pursuant to this article.

3. a. As a condition to receiving the commissioner's authorization under this section, an operator shall establish a government insured

interest-bearing account, which earns interest at a rate which is consistent with prevailing interest rates, and enter into an escrow agreement with a New York state bank, New York state savings and loan association or New York state trust company for the deposit of any priority reservation fees collected by the operator pursuant to this section, which escrow funds shall be subject to release as provided for in this section.

b. The escrow agreement shall state that its purpose is to protect prospective residents who have paid a priority reservation fee to the operator in order to guarantee prospective residents an opportunity for priority placement in the fee-for-service continuing care retirement community for which the operator has been issued a certificate of authority and that, upon presentation of evidence of compliance with applicable provisions of this article, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the operator, the prospective resident or the prospective resident's legal representative as directed, within fifteen business days of receipt of the notice by the escrow agent.

c. Checks, drafts, and money orders for deposit from prospective residents shall be made payable to the escrow agent only.

d. All funds deposited in the escrow account shall remain the property of the prospective residents until released to the operator in accordance with this section, and the funds shall not be subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the operator.

e. At the request of the operator, the commissioner or a prospective resident, the escrow agent shall issue a statement indicating the status of the escrow account.

f. A prospective resident's escrowed funds shall not be released to an operator unless the prospective resident has elected to apply the

priority reservation fee to an actual entrance fee or deposit on an entrance fee. Upon release to the operator, a prospective resident's escrowed priority reservation fee funds shall be deposited into the entrance fee escrow account provided for in section forty-six hundred sixty-two of this article; provided that the operator may retain such funds and shall not be required to deposit them in the entrance fee escrow account if the prospective resident's living unit is available for occupancy.

g. If the funds in an escrow account under this section, and any interest thereon, are not released to the operator within such time as provided by rules and regulations adopted by the council, then such funds shall be returned by the escrow agent to the persons who had made the payments or the person's legal representative.

h. A priority reservation fee, and the interest accrued thereon, held in escrow shall be returned by the escrow agent to the person who paid the fee upon receipt by the escrow agent of notice from the operator or the person who paid the fee or the person's legal representative that the priority reservation agreement has been canceled. Any priority reservation fee, and the interest accrued thereon, shall be returned by the escrow agent to the person who paid the fee or the person's legal representative within fifteen business days of receipt by the escrow agent of notice of cancellation of the priority reservation agreement.

i. Refunds of priority reservation fees upon the death of a prospective resident will be made upon the same basis as refunds upon cancellation of a priority reservation agreement.

j. Nothing in this section shall be interpreted as requiring the escrow of any non-refundable priority reservation agreement application fee, designated as such in the cancelable priority reservation agreement, which fee is received by the operator from a prospective resident.

4. Any marketing materials, including all materials associated with a sales office and model units, used in the solicitation of priority

reservation agreements or priority reservation fees shall, at a minimum contain the following:

a. a statement that the purpose of the marketing material is for the operator to offer prospective residents an opportunity for a guaranteed priority placement in a fee-for-service continuing care retirement community by entering into cancelable priority reservation agreements and accepting refundable priority reservation fees;

b. a statement that the cancelable priority reservation agreement is not a fee-for-service continuing care contract and may be canceled by the person entering the agreement or the person's legal representative at any time, without cause; and

c. a statement that any priority reservation fees paid shall be held in escrow and shall be refunded, together with interest accrued at prevailing rates, to the person paying the fee or the person's legal representative upon request and cancellation of the priority reservation agreement.

5. Any priority reservation fees with respect to a fee-for-service continuing care retirement community may be collected only after issuance of a cancelable priority reservation agreement to the person paying the fee, which agreement shall contain the following information:

- a. the name and location of the community;
- b. the name and address of the operator;
- c. the name, address and phone number of a contact person;
- d. the name and address of the person paying the fee;
- e. the name and address of the escrow agent;
- f. the type of unit being reserved;

g. the current entry fee and monthly care fee, together with a statement explaining that these fees are subject to change and may be changed by the time the prospective resident has entered into a fee-for-service continuing care contract with the operator;

h. the amount of any non-refundable priority reservation agreement application fee;

i. a notice in bold twelve point type that the cancelable priority reservation agreement does not obligate the person entering into the agreement in any way; that there is no guarantee by the operator that the current fees set forth in the agreement will not change; that the person paying the priority reservation fee may receive a refund of the fee plus interest accrued at prevailing rates upon request; and that he or she shall be entitled on a priority basis to apply the priority reservation fee to an actual entrance fee or entrance fee deposit on a unit not already under contract;

j. the signature of the person paying the fee and the signature of the operator or the operator's agent;

k. a statement that the effective period of the agreement shall not exceed the duration of the commissioner's authorization; and

l. an outline of the fees, their associative service, and guidelines used for changing the residency status of a resident.

6. a. In order to approve an application under this section, the commissioner shall have determined that:

(i) the operator has satisfied the requirements of this section and any applicable regulations; and

(ii) the operator can be expected to meet its obligations in accordance with this section and in accordance with its priority reservation agreements with prospective residents.

b. If the commissioner approves an application, the commissioner shall issue a written authorization to the operator authorizing the operator

to enter into cancelable priority reservation agreements and collect refundable priority reservation fees from prospective residents concerning the fee-for-service continuing care retirement community.

c. The commissioner's authorization shall remain in effect as long as the operator's certificate of authority for its community remains in effect; provided that the commissioner may rescind the authorization at any time for just cause, including any material misstatement of fact or misrepresentation in any of the application materials or any materials subsequently disseminated.

d. The operator shall provide written notice to all parties who have entered into cancelable priority reservation agreements of the commissioner's rescision of authorization to enter into cancelable priority reservation agreements.

e. The commissioner shall provide written notice to the escrow agent of the commissioner's rescision of authorization to enter into cancelable priority reservation agreements, including instructions to release funds held in escrow to the persons who have paid refundable priority reservation fees.

§ 4676. Industrial development agency financing. Fee-for-service continuing care retirement communities developed pursuant to this article shall be eligible for industrial development financing in accordance with section forty-six hundred four-a of this chapter except for paragraphs b and g of subdivision two of such section and financing by any public benefit corporation authorized to make loans to continuing care retirement communities under the laws of this state provided, however, the operator of such fee-for-service continuing care retirement community has demonstrated capability to comply fully with the requirements for a certificate of authority and has obtained a contingent certificate of authority pursuant to section forty-six hundred fifty-five of this article and the operator has agreed to meet the requirements of article eighteen-A of the general municipal law.

ARTICLE 46-B

ASSISTED LIVING

- Title I. Findings and definitions (§§ 4650*2-4651*2).
Title II. Assisted living (§§ 4652*2-4653-A).
Title III. Enhanced assisted living certificate (§§ 4654*2-4655*2).
Title IV. General requirements (§§ 4656*2-4663*2).

TITLE I

FINDINGS AND DEFINITIONS

- Section 4650*2. Legislative purpose and findings.
4651*2. Definitions.

*** § 4650. Legislative purpose and findings.** The legislature hereby finds and declares that congregate residential housing with supportive services in a home-like setting, commonly known as assisted living, is an integral part of the continuum of long term care. Further, the philosophy of assisted living emphasizes aging in place, personal dignity, autonomy, independence, privacy and freedom of choice.

The intent of this article is to create a clear and flexible statutory structure for assisted living that provides a definition of assisted living residence; that requires licensure of the residence; that requires a written residency agreement that contains consumer protections; that enunciates and protects resident rights; and that provides adequate and accurate information for consumers, which is essential to the continued development of a viable market for assisted living. Entities which hold themselves out as assisted living residences must apply for licensure and be approved by the state to operate as assisted living residences pursuant to this article, and must comply with the requirements of this article.

* NB There are 2 § 4650's

*** § 4651. Definitions.** As used in this article:

1. "Assisted living" and "assisted living residence" means an entity which provides or arranges for housing, on-site monitoring, and personal care services and/or home care services (either directly or indirectly), in a home-like setting to five or more adult residents unrelated to the assisted living provider. An applicant for licensure as assisted living that has been approved in accordance with the provisions of this article must also provide daily food service, twenty-four hour on-site monitoring, case management services, and the development of an individualized service plan for each resident. An operator of assisted living shall provide each resident with considerate and respectful care and promote the resident's dignity, autonomy, independence and privacy in the least restrictive and most home-like setting commensurate with the resident's preferences and physical and mental status.

Assisted living and enhanced assisted living shall not include:

(a) residential health care facilities or general hospitals licensed under article twenty-eight of this chapter;

(b) continuing care retirement communities which possess a certificate of authority pursuant to article forty-six of this chapter, unless the continuing care retirement community is operating an assisted living residence as defined under this section;

(c) residential services for persons that are provided under a license pursuant to article sixteen, nineteen, thirty-one or thirty-two of the mental hygiene law or other residential services primarily funded by or primarily under the jurisdiction of the office for mental health;

(d) naturally occurring retirement communities, as defined in section five hundred thirty-six-g of the executive law;

(e) assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law;

(f) public or publicly assisted multi-family housing projects administered or regulated by the U.S. department of housing and urban development or the division of housing and community renewal or funded through the homeless housing assistance program that were designed for the elderly or persons with disabilities, or homeless persons, provided such entities do not provide or arrange for home care, twenty-four hour supervision or both, beyond providing periodic coordination or

arrangement of such services for residents at no charge to residents. Except, however, such entities that are in receipt of grants for conversion of elderly housing to assisted living facilities pursuant to section 1701-q-2 of the United States Code shall license as an assisted living pursuant to this article;

(g) an operating demonstration as such term is defined in paragraph (d) of subdivision one of section four thousand four hundred three-f of this chapter;

(h) hospice and hospice residences as defined pursuant to section four thousand two of this chapter;

(i) an adult care facility as defined in subdivision twenty-one of section two of the social services law that is not utilizing the term assisted living (or any derivation thereof) or is not required to obtain an enhanced assisted living certificate; and

(j) independent senior housing, shelters or residences for adults. For purposes of this article and for purposes of determining certification pursuant to article seven of the social services law, the department shall by regulation, define independent senior housing, provided such definition shall be based on whether the operator does not provide, arrange for, or coordinate personal care services or home care services on behalf of residents; and the facility does not provide case management services in a congregate care setting for residents. Nothing in this chapter shall preclude a resident of independent senior housing from personally and directly obtaining private personal care or home care services from a licensed or certified home care agency.

2. "Applicant" shall mean the entity which submits an assisted living licensure application with the department pursuant to title two or three of this article.

3. "Adult home" means an adult home as defined by subdivision twenty-five of section two of the social services law.

4. "Enriched housing program" means an enriched housing program, as defined in subdivision twenty-eight of section two of the social services law.

5. "Assisted living operator" or "operator" means a person, persons or an entity which has obtained the written approval of the department to operate an assisted living residence in accordance with this article.

6. "Controlling person" means any person who by reason of a direct or indirect ownership interest, whether of record or beneficial, has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said corporation, partnership or other entity.

7. "Resident" means an adult not related to the provider, who, pursuant to a residency agreement with a provider resides in an assisted living or enhanced assisted living residence, as applicable.

8. "Resident's representative" means a family member or other individual identified in the residency agreement required under section four thousand six hundred fifty-eight of this article who is authorized by a resident to communicate with residence employees regarding the health, well-being, needs of and services provided to such resident and to assist the resident in obtaining needed services.

9. "Resident's legal representative" means a person duly authorized under applicable state law to act on behalf of a resident. Such legal representative could include, but is not necessarily limited to, a court appointed guardian, an attorney in-fact under a durable power of attorney, an agent under a health care proxy or a representative payee, depending upon the action to be taken.

10. "Home care services" means the services defined in subdivision one of section three thousand six hundred two of this chapter, as provided by a home care services agency which has been approved to operate pursuant to article thirty-six of this chapter.

11. "Individualized service plan" or "ISP" means a written plan developed pursuant to section four thousand six hundred fifty-nine of this article.

12. "Monitoring" means an ability of the assisted living provider to respond to urgent or emergency needs or requests for assistance with appropriate staff, at any hour of any day or night of the week. Such monitoring must be provided on site.

13. "Aging in place" means, care and services at a facility which possesses an enhanced assisted living certificate which, to the extent practicable, within the scope of services set forth in the written residency agreement executed pursuant to section four thousand six hundred fifty-eight of this article, accommodates a resident's changing needs and preferences in order to allow such resident to be admitted to or remain in the residence as long as the residence is able and authorized to accommodate the resident's current and changing needs. A residence that does not possess an enhanced assisted living certificate shall not be deemed able to accommodate a resident's needs if the resident requires or is in need of either enhanced assisted living or twenty-four hour skilled nursing care or medical care provided by facilities licensed pursuant to article twenty-eight of this chapter or article nineteen, thirty-one or thirty-two of the mental hygiene law.

14. "Enhanced assisted living" or "enhanced assisted living resident" means the care or services provided, or a resident who is provided the care and services, pursuant to an enhanced assisted living certificate.

15. "Enhanced assisted living certificate" means a certificate issued by the department which authorizes an assisted living residence to provide aging in place by either admitting or retaining residents who desire to age in place and who: (a) are chronically chairfast and unable to transfer, or chronically require the physical assistance of another person to transfer; (b) chronically require the physical assistance of another person in order to walk; (c) chronically require the physical assistance of another person to climb or descend stairs; (d) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or (e) has chronic unmanaged urinary or bowel incontinence. In no event shall a person be admitted to an assisted living residence who is in need of continual twenty-four hour nursing or medical care, who is chronically bedfast, or

who is cognitively, physically or medically impaired to such a degree that his or her safety would be endangered.

* NB There are 2 § 4651's

TITLE II **ASSISTED LIVING**

Section 4652*2. General requirements; applicability of laws to assisted living.

4653*2. Licensure procedures and requirements for assisted living.

4653-A. Closure of assisted living residences.

*** § 4652. General requirements; applicability of laws to assisted living.** Adult homes and enriched housing programs which possess a valid operating certificate issued pursuant to title two of article seven of the social services law, may call themselves assisted living provided they:

1. file an application for licensure and are approved by the department as assisted living;

2. comply with all the requirements of this article.

* NB There are 2 § 4652's

*** § 4653. Licensure procedures and requirements for assisted living.**
1. In order to operate as assisted living, an operator shall be licensed as an adult home or enriched housing program and apply and be approved for licensure with the commissioner pursuant to this article. The operator shall provide, on an application form developed by the commissioner, the following information to the commissioner in order to be licensed:

(a) business name, street address, and mailing address of the residence and of the owners of the residence;

(b) status of current operating certificate;

(c) verification that the operator has a valid residency agreement in compliance with this article to be entered into with each resident, resident's representative and resident's legal representative, if any, and shall include a copy of the information to be included in the residency agreement and disclosures as required pursuant to the provisions of section four thousand six hundred fifty-eight of this article, as added by chapter two of the laws of two thousand four, that will be given to prospective residents; and

(d) any other information the department may deem necessary for the evaluation of the application provided such information is not duplicative of what is otherwise required of the applicant in obtaining an adult care facility license.

2. For existing licensed operators in good standing and their affiliates, the department shall develop a streamlined application review and approval process, in collaboration with representatives of associations of operators, to be available for use in relation to approval of an additional facility of the same type. Notwithstanding any provision of law or regulation to the contrary, the streamlined application review and approval process shall include, but not be limited to, the following:

(a) a certification process and form for the operator or its affiliate to attest that it will have sufficient financial resources, revenue and financing to meet facility expenses and resident needs, which shall satisfy the statutory and regulatory financial component of the application review and approval process;

(b) a certification process and form for the operator or its affiliate to attest that its legal, corporate and organizational documents comply in substance with department requirements, which shall satisfy the statutory and regulatory legal component of the application review and approval process;

(c) a certification process and form for the operator or its affiliate to attest that it is in substantial compliance with all applicable codes, rules and regulations in any other state in which it operates, and to disclose any enforcement or administrative action taken against it in any other state;

(d) issuance by the department of a conditional approval to operate

the facility for a specified period of time upon substantial completion of the character and competence, legal, financial and architectural components of the application, so long as the operator or its affiliate agrees in writing to satisfy all pending conditions prior to the expiration of the conditional approval period or a time frame established by the department;

(e) issuance by the department of a conditional approval to construct a facility, at the operator's or its affiliate's own risk, upon substantial completion of the architectural component of the application;

(f) elimination of duplicative submission and review of any application information which has been previously reviewed and approved by the department or any of its regional offices within the past two years through a certification process and form whereby the operator or its affiliate will attest that such application information is duplicative;

(g) with respect to any programmatic application information to be reviewed by the regional office, such review shall be conducted on-site by the regional office during the pre-opening inspection or first full annual inspection, if the department has previously approved the operator or its affiliate to operate the same type of program at another facility within the past two years;

(h) electronic submission of applications; and

(i) a combined application for licensure as an adult care facility, assisted living residence and/or assisted living program, to the extent the department determines such a combined application is feasible.

2-a. For purposes of subdivision two of this section, "affiliate" shall mean an entity, for which a majority of the ownership or controlling interest is the same as the ownership or controlling interest in an existing licensed operator under this section (provided that an affiliate may have different percentages of ownership or control or fewer natural persons with ownership or control than an existing licensed operator) and, further:

(a) for any entity owned, directly or indirectly, by natural persons:

(i) at all times, more than half of the ownership interest of the entity shall be owned, directly or indirectly, by natural persons who

have previously been determined to have undergone a satisfactory determination of character, competence and standing in the community;

(ii) at all times, any owner with a direct or indirect ownership interest who has not undergone a satisfactory determination of character, competence and standing in the community review must possess a less than ten percent direct or indirect interest in the entity, until a satisfactory determination has been made; and

(iii) for any natural person proposed to be an owner, directly or indirectly, of the entity who is a controlling person, as defined in section four hundred sixty-one-b of the social services law, or is a member, director, or officer of an existing licensed operator under this section, such existing licensed operator must be in good standing with the department; and

(b) for any not-for-profit corporation or other entity not under paragraph (a) of this subdivision:

(i) more than half of the entity's total board members, directors, officers and controlling persons, as defined in section four hundred sixty-one-b of the social services law, shall have previously undergone a satisfactory determination of character, competence and standing in the community; and

(ii) if any natural person proposed to be a board member, director, or officer of the entity has an ownership interest, directly or indirectly, or is a board member, director, officer, or controlling person, as defined in section four hundred sixty-one-b of the social services law, in an existing licensed operator under this section, such existing licensed operator must also be in good standing with the department.

2-b. For purposes of subdivision two of this section, "good standing" shall mean the operator and its affiliate have not (i) received any official written notice from the department of a proposed revocation, suspension, denial or limitation on the operating certificate of the facility or residence; (ii) within the previous three years, been assessed a civil penalty after a hearing conducted pursuant to subparagraph one of paragraph (b) of subdivision seven of section four hundred sixty-d of the social services law for a violation that has not been rectified; (iii) within the previous year, received any official written notice from the department of a proposed assessment of a civil

penalty for a violation described in subparagraph two of paragraph (b) of subdivision seven of section four hundred sixty-d of the social services law; (iv) within the previous three years, been issued an order pursuant to subdivision two, five, six, or eight of section four hundred sixty-d of the social services law; (v) within the previous three years, been placed on, and if placed on, removed from the department's "do not refer list" pursuant to subdivision fifteen of section four hundred sixty-d of the social services law. Provided, however, that in the case of an operator or affiliate that is not in good standing as provided in this paragraph, the department may permit the operator or affiliate to use the streamlined application process, in its discretion, if it determines that the disqualifying violation was an isolated occurrence that was promptly corrected by the operator or affiliate.

* NB There are 2 § 4653's

§ 4653-a. Closure of assisted living residences. 1. In the event that an operator of an assisted living residence elects to close and to surrender an operating certificate and/or certification as an enhanced or special needs assisted living residence, the following provisions shall apply:

(a) The operator shall notify the appropriate regional office of the department and the office of the state long-term care ombudsman in writing prior to the anticipated date of closure of the assisted living residence and/or the decertification of the assisted living residence.

(b) The written notice shall include a proposed plan for closure and/or decertification. The plan shall be subject to the approval of the commissioner, shall include timetables for all steps entailed in the closure process and shall describe the procedures and actions the operator will take to:

(i) notify residents and the residents' representatives of the closure, and/or decertification, including provisions for termination of residency agreements and involuntary discharge;

(ii) assess the needs and preferences of individual residents;

(iii) assist residents in relocating and transferring to appropriate alternative settings; and

(iv) maintain compliance with approved plan until all residents have

relocated.

(c) The plan of closure shall be reviewed by the commissioner within ninety days of submission.

2. (a) The operator shall take no action to close the assisted living residence prior to approval from the commissioner of the plan for closure and/or decertification.

(b) The operator shall not close the assisted living residence until all residents thereof have transferred to appropriate alternative settings.

(c) The operator shall not increase the amount of any rent, fees or other surcharges imposed upon the residents of the assisted living residence, their residents' representatives, and/or any applicable health insurance plan, long term care plan or other insurance plan providing payment to the residence on behalf of the resident prior to the approval of the plan for closure and/or decertification by the commissioner; provided that an operator shall not be prohibited from amending a residency agreement to account for changes in supplemental security income however, the total of the changes for an individual shall not exceed the amount of the increase in the individual's supplemental security income. The operator shall provide each resident, as applicable, written notice of any increase not less than forty-five days prior to the proposed effective date of the fee increase consistent with the notice requirement in section forty-six hundred sixty of this article.

(d) The operator shall not accept new residents or applications for residency after the operator has notified the appropriate regional office of the department that the operator intends to close and/or decertify the assisted living residence.

3. As part of the final approval of the closure plan, the department and operator shall agree upon a target closure date, which shall be at least one hundred twenty days from the actual date that the operator provides written notification to the residents and the residents' representatives of the closure. In providing notification of such target closure date, the operator shall also notify residents and the residents' representatives that additional time will be provided to

residents who make good faith efforts, as determined by the commissioner, to secure an alternative setting and have demonstrated a reasonable basis for needing more than one hundred twenty days to transfer to an appropriate alternative setting, so long as it remains safe and appropriate to reside in the assisted living residence at the time.

4. The operator shall implement the approved plan to ensure that arrangements for continued care which meet each resident's social, emotional and health care needs are effectuated prior to closure and/or decertification.

5. Failure to notify the department of intent to cease operations, failure to submit a plan for closure and/or decertification, failure to execute the approved plan for closure and/or decertification and closing an assisted living residence before all residents have been appropriately relocated, shall result in the imposition of civil penalties in accordance with section twelve of this chapter.

6. The commissioner may make such rules and regulations as he or she deems necessary to implement this section.

TITLE III

ENHANCED ASSISTED LIVING CERTIFICATE

Section 4654*2. General requirements; applicability of laws to enhanced assisted living.

4655*2. Certification procedures and requirements.

*** § 4654. General requirements; applicability of laws to enhanced assisted living.** Nothing in this article shall require a residence to obtain an enhanced assisted living certificate pursuant to this title unless such residence elects to provide aging in place by retaining residents described in subdivision fifteen of section four thousand six hundred fifty-one of this article.

* NB There are 2 § 4654's

*** § 4655. Certification procedures and requirements. 1.**

Notwithstanding any other provision of law, an assisted living operator may apply to the department to obtain an enhanced assisted living certificate pursuant to this section.

(a) Such application shall be on a form approved by the department.

(b) An assisted living operator may apply for such a certificate for the entire facility or any number of beds at the facility.

(c) To obtain an enhanced assisted living certificate, the applicant must submit a plan to the department setting forth how the additional needs of residents will be safely and appropriately met at such residence. Such plan shall include, but need not be limited to, a written description of services, staffing levels, staff education and training, work experience, and any environmental modifications that have been made or will be made to protect the health, safety and welfare of such persons in the residence.

(d) In addition to any other requirements of assisted living, an operator of enhanced assisted living may hire care staff directly pursuant to standards developed by the department or contract with a home care services agency which has been approved to operate pursuant to article thirty-six of this chapter.

(e) No assisted living residence shall be certified as enhanced assisted living unless and until the applicant obtains the written approval of the department.

2. No resident shall be permitted to continue to age in place under the terms of an enhanced assisted living certificate unless the operator, the resident's physician, and, if applicable, the resident's licensed or certified home care agency, agree that the additional needs of the resident can be safely and appropriately met at the residence. A resident eligible for enhanced assisted living or his or her representative shall submit to the residence a written report from a physician, which report shall state that:

(a) the physician has physically examined the resident within the last month; and

(b) the resident is not in need of twenty-four hour skilled nursing

care or medical care which would require placement in a hospital or residential health care facility.

3. The residence must notify a resident that, while the residence will make reasonable efforts to facilitate the resident's ability to age in place pursuant to an individualized service plan, there may be a point reached where the needs of the resident cannot be safely or appropriately met at the residence, requiring the transfer of the resident to a more appropriate facility in accordance with the provisions of this article.

4. If a resident reaches the point where he or she is in need of twenty-four hour skilled nursing care or medical care required to be provided by facilities licensed pursuant to article twenty-eight of this chapter or article nineteen, thirty-one or thirty-two of the mental hygiene law, then the resident must be discharged from the residence and the operator shall initiate proceedings for the termination of the residency agreement of such resident in accordance with the provisions of section four hundred sixty-one-h of the social services law. Provided, however, a resident may remain at the residence if each of the following conditions are met:

(a) a resident in need of twenty-four hour skilled nursing care or medical care hires appropriate nursing, medical or hospice staff to care for his or her increased needs;

(b) the resident's physician and home care services agency both determine and document that, with the provision of such additional nursing, medical or hospice care, the resident can be safely cared for in the residence, and would not require placement in a hospital, nursing home or other facility licensed under article twenty-eight of this chapter or article nineteen, thirty-one or thirty-two of the mental hygiene law;

(c) the operator agrees to retain the resident and to coordinate the care provided by the operator and the additional nursing, medical or hospice staff; and

(d) the resident is otherwise eligible to reside at the residence.

5. In addition to the requirements otherwise required for licensure as

assisted living, any residence that advertises or markets itself as serving individuals with special needs, including, but not limited to, individuals with dementia or cognitive impairments, must submit a special needs plan to the department setting forth how the special needs of such residents will be safely and appropriately met at such residence. Such plan shall include, but need not be limited to, a written description of specialized services, staffing levels, staff education and training, work experience, professional affiliations or special characteristics relevant to serving persons with special needs, and any environmental modifications that have been made or will be made to protect the health, safety and welfare of such persons in the residence. In approving an application for special needs certification, the department shall develop standards to ensure adequate staffing and training in order to safely meet the needs of the resident. The standards shall be based upon recommendations of the task force established by section five of the chapter of the laws of two thousand four which added this section. No residence shall market themselves as providing specialized services unless and until the department has approved such applicant for a special needs assisted living certificate.

6. An enhanced assisted living certificate shall not be required of an adult care facility, or part thereof, which has obtained approval by the department to operate an assisted living program pursuant to section four hundred sixty-one-l of the social services law. Provided, however, such exemption shall only apply to those beds at the facility which are subject to the assisted living program.

* NB There are 2 § 4655's

TITLE IV

GENERAL REQUIREMENTS

Section 4656*2. General requirements; applicability of laws to assisted living and enhanced assisted living.

4657*2. Residency admission.

4658*2. Residency agreement and disclosures.

4659*2. Individualized service plan.

4660*2. Rights of residents in assisted living residences.

4661*2. Resident funds.

4662*2. Powers of the commissioner.

4663*2. Penalties and enforcement.

*** § 4656. General requirements; applicability of laws to assisted living and enhanced assisted living.** 1. No entity shall establish, operate, provide, conduct, or offer assisted living in this state, or hold itself out as an entity which otherwise meets the definition of assisted living or advertise itself as assisted living or by a similar term, without obtaining the approval of the department to operate as an adult care facility pursuant to title two of article seven of the social services law, obtaining the approval of the department as required in this article, and otherwise acting in accordance with this article. Provided however that an entity may simultaneously apply for approval to operate as an adult care facility and as an assisted living residence pursuant to this article. This subdivision shall not apply to assisted living programs approved by the department pursuant to section four hundred sixty-one-1 of the social services law.

2. An assisted living operator shall comply with all applicable statutes, rules and regulations required for maintaining a valid operating certificate issued pursuant to title two of article seven of the social services law and shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required in addition to requirements under this article.

3. Approval for licensure or certification pursuant to this article may be granted only to an applicant who satisfactorily demonstrates:

(a) that such applicant possesses a valid operating certificate to operate as an adult home or enriched housing program pursuant to article seven of the social services law. An applicant that does not currently possess such operating certificate as an adult home or enriched housing program may simultaneously apply and be approved for such certificate and all other licenses and certifications authorized under this article;

(b) that such applicant which has an existing valid adult care facility operating certificate, is in good standing with the department.

For purposes of this subdivision, good standing shall mean the applicant has not (i) received any official written notice from the department of a proposed revocation, suspension, denial or limitation on the operating certificate of the facility or residence; (ii) within the previous three years, been assessed a civil penalty after a hearing conducted pursuant to subparagraph one of paragraph (b) of subdivision seven of section four hundred sixty-d of the social services law for a violation that has not been rectified; (iii) within the previous year, received any official written notice from the department of a proposed assessment of a civil penalty for a violation described in subparagraph two of paragraph (b) of subdivision seven of section four hundred sixty-d of the social services law; (iv) within the previous three years, been issued an order pursuant to subdivision two, five, six, or eight of section four hundred sixty-d of the social services law; (v) within the previous three years, been placed on, and if placed on, removed from the department's "do not refer list" pursuant to subdivision fifteen of section four hundred sixty-d of the social services law. Provided however that in the case of an applicant which otherwise meets the requirements of this section, but is not in good standing as provided in this paragraph, the department may approve said applicant if it determines that the applicant is of good moral character and is competent to operate the residence. Such character and competence review shall be limited to applicants not in good standing pursuant to this paragraph or an applicant subject to paragraph (f) of this subdivision. As part of the review provided pursuant to this paragraph, the department shall, on its webpage, solicit and consider public comment;

(c) that such applicant has adequate financial resources to provide such assisted living as proposed;

(d) that the building, equipment, staff, standards of care and records to be employed in the operation comply with applicable statutes and any applicable local law;

(e) that any license or permit required by law for the operation of such residence has been issued to such operator; and

(f) in the case of an applicant which does not have an existing valid adult care facility operating certificate, such applicant shall otherwise comply with the provisions for certification as prescribed by article seven of the social services law.

4. The department shall develop an expedited review and approval process for applications for up to nine additional beds to an existing enhanced or special needs assisted living certificate qualified as being in good standing under section forty-six hundred fifty-three of this article.

5. The knowing operation of an assisted living or enhanced assisted living residence without the prior written approval of the department shall be a class A misdemeanor.

6. Every assisted living residence that is required to possess an assisted living residence license shall be licensed on a biennial basis and shall pay a biennial licensure fee. Such fee shall be five hundred dollars per license, with an additional fee of fifty dollars per resident whose annual income is above four hundred percent of the federal poverty level. Such additional fee shall be based on the total occupied beds at the time of application, up to a maximum biennial licensure fee of five thousand dollars. Said fee shall be in addition to the fee charged by the department for certification as an adult care facility. Every assisted living residence that applies for an enhanced assisted living certificate or a special needs assisted living certificate shall pay an additional biennial fee, in addition to any other fee required by this subdivision, in the amount of two thousand dollars, provided that for any residence applying for both an enhanced assisted living certificate and a special needs assisted living certificate the amount of such fee shall be three thousand dollars.

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

(i) report annually on quality measures to be established by the department, in consultation with industry and consumer representatives, including the long-term care ombudsman or their representative, in the form and format prescribed by the department, with the first report due no later than April fifteenth, two thousand twenty-five; and

(ii) post information, including the starting monthly service rate, range for starting rent, approved admission or residency agreement, and a consumer-friendly summary of all service fees, through a reporting system to be developed by the department, in consultation with industry and consumer representatives, that takes into account differences in licensure and certification, services, agreements and fee structures across facilities. Such information shall be posted in a conspicuous place on the facility's website and in a public space within the facility and shall be made available to the public on forms developed by the department. Beginning on January first, two thousand twenty-five, this information shall also be reported to the department.

(b) The department shall develop a system to score the results of the assisted living quality reporting obtained pursuant to paragraph (a) of this subdivision, in consultation with industry and consumer representatives. Facilities scoring in the top quartile shall be granted the classification of advanced standing on their annual surveillance schedules.

Facilities may remain on advanced standing classification provided they meet the scoring requirements in assisted living quality reporting and until such time when they do not meet such scoring requirements.

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

(d) No later than December thirty-first, two thousand twenty-five, the department shall report to the legislature on the development of a quality scoring system for adult care facilities, including adult homes and enriched housing providers. Such report shall examine the specific quality measures recommended and a process for information collection.

8. (a) Assisted living residences, as defined in subdivision one of section forty-six hundred fifty-one of this article, including those licensed and certified as an assisted living residence, special needs assisted living residence, or enhanced assisted living residence, may seek accreditation by agencies determined by the commissioner.

(b) Such accreditation agencies shall report data and information, in

a manner and form as determined by the department, pertaining to those assisted living residences accredited by such agencies, and those assisted living residences which obtain but lose such accreditation.

9. The requirements of this article shall be in addition to those required of an adult care facility. In the event of a conflict between any provision of this article and a provision of article seven of the social services law or a regulation adopted thereunder, the applicable provision of this article or the applicable regulation shall supersede article seven of the social services law or the applicable regulation thereunder to the extent of such conflict.

10. The assisted living operator shall not use deceptive or coercive marketing practices to encourage residents or potential residents to sign or reauthorize the residency agreement required pursuant to section four thousand six hundred fifty-eight of this article.

* NB There are 2 § 4656's

*** § 4657. Residency admission.** 1. An assisted living operator shall conduct an initial pre-admission evaluation of a prospective resident to determine whether or not the individual is appropriate for admission to the assisted living residence. Such evaluation shall be conducted by the operator and, if necessary, in conjunction with a home care services agency or appropriate employee pursuant to paragraph (d) of subdivision one of section four thousand six hundred fifty-five of this article. The operator shall conduct all such evaluations using an evaluation tool developed by the department, to be based on the recommendations of the task force created pursuant to section five of the chapter of the laws of two thousand four which added this section or one developed by the operator that receives approval by the department.

2. The assisted living operator shall not admit any resident if the operator is not able to meet the care needs of the resident within the scope of services authorized under this article, and the individualized service plan; provided, further that no operator shall admit any resident in need of twenty-four hour skilled nursing care.

3. (a) At the time of the admission to an assisted living residence, a resident shall submit to the facility a written report from a physician, a physician assistant or a nurse practitioner, which report shall state:

(i) that the physician, physician assistant or nurse practitioner has physically examined the resident within one month and the date of such examination;

(ii) that the resident is not in need of acute or long term medical or nursing care which would require placement in a hospital or residential health care facility; and

(iii) that the resident is not otherwise medically or mentally unsuitable for care in the facility.

(b) For the purpose of creating an accessible and available record and assuring that a resident is properly placed in such a facility, the report shall contain the resident's significant medical history and current conditions, the prescribed medication regimen, recommendations for diet, the assistance needed in the activities of daily living, and where appropriate, recommendations for exercise, recreation and frequency of medical examinations.

(c) Such resident shall thereafter be examined by a physician, a physician assistant or a nurse practitioner at least annually, and shall submit an annual written report in conformity with the provisions of this subdivision.

(d) Following a resident's stay in a hospital or residential health care facility, upon return to the assisted living residence, the assisted living residence shall not be required to obtain the report in paragraph (a) of this subdivision, and instead shall obtain a statement from the discharging facility which shall:

(i) state that the resident is appropriate to return to the residence; and

(ii) include the reason for the stay, the treatment plan to be followed, and any new or changed orders, including medications.

The statement shall be completed by a physician, a physician assistant or a nurse practitioner.

(e) Nothing required in this subdivision shall require the use of an identical form in adult care facilities and assisted living residences,

either upon admission or return.

* NB There are 2 § 4657's

*** § 4658. Residency agreement and disclosures.** 1. Every operator shall execute with each resident a written residency agreement, in no less than twelve point type and written in plain language, which satisfies the requirements of this section. Such agreement shall:

(a) be dated and signed by the operator, the resident, resident's representative, and resident's legal representative, if any, and any other party to be charged under the agreement;

(b) contain the entire agreement of the parties and shall include the disclosures required by subdivision three of this section.

1-a. The resident, resident's representative and resident's legal representative, if any, shall be given a complete copy of the agreement and all supporting documents and attachments and any changes whenever changes are made to the agreement.

2. The residency agreement shall include, at a minimum:

(a) the name, telephone number, street address and mailing address of the residence;

(b) the name and mailing address of the owner of the residence and at least one natural person authorized to accept personal service on behalf of the owner of the residence;

(c) the name and address of the assisted living operator and at least one natural person authorized to accept personal service on behalf of the operator;

(d) a statement, to be updated as necessary, describing the licensure or certification status of the assisted living operator and any provider offering home care services or personal care services under an arrangement with the residence, including a specific listing of such providers;

(e) the effective period of the agreement;

(f) a description of the services to be provided to the resident and the base rate to be paid by the resident for those services;

(g) a description of any additional services available for an

additional, supplemental, or community fee from the assisted living operator directly or through arrangements with the operator, stating who would provide such services, if other than such operator;

(h) a rate or fee schedule, including any additional, supplemental, or community fees charged for services provided to the resident, with a detailed explanation of which services and amenities are covered by such rates, fees, or charges;

(i) a description of the process through which the agreement may be modified, amended, or terminated, and setting forth the terms and time frames under which the agreement may be terminated by either party;

(j) a description of the complaint resolution process available to residents;

(k) the name of the resident's representative and resident's legal representative, if any, and a description of the representative's responsibilities;

(l) the criteria used by the operator to determine who may be admitted and who may continue to reside in the residence, including criteria related to the resident's care needs and compliance with reasonable rules of the residence;

(m) procedures and standards for termination of contract, discharge and transfer to another dwelling or facility;

(n) billing and payment procedures and requirements;

(o) procedures in the event the resident, resident's representative or resident's legal representative are no longer able to pay for services provided for in the resident agreement or for additional services or care needed by the resident; and

(p) terms governing the refund of any previously paid fees or charges in the event of a resident's discharge from the assisted living residence or termination of the resident agreement.

3. In conjunction with any marketing materials and with the residency agreement required by this section, the assisted living operator shall disclose on a separate information sheet in plain language and in twelve point type the following to (a) any individual who expresses an interest in residing in the residence, and to his or her designated representative and his or her legal representative, if any, upon request or prior to admission, whichever occurs first, and (b) any current

resident and to his or her designated representative and his or her legal representative, if any, if such information has not previously been disclosed to them:

(i) the consumer information guide developed by the commissioner pursuant to subdivision one of section forty-six hundred sixty-two of this title;

(ii) a statement listing the residence's licensure and if it has an enhanced assisted living certificate and/or special needs enhanced assisted living certificate and the availability of enhanced assisted living and/or special needs beds;

(iii) any ownership interest in excess of ten percent on the part of the operator, whether legal or beneficial, in any entity which provides care, material, equipment or other services to residents;

(iv) any ownership interest in excess of ten percent on the part of any entity which provides care, material, equipment or other services to residents, whether legal or beneficial, in the operator;

(v) a statement regarding the ability of residents to receive services from service providers with whom the operator does not have an arrangement;

(vi) a statement that residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary;

(vii) a statement regarding the availability of public funds for payment for residential, supportive or home health services including, but not limited to availability of coverage of home health services under title eighteen of the federal social security act (Medicare);

(viii) the department's toll free telephone number for reporting of complaints regarding home care services and the services provided by the assisted living operator; and

(ix) a statement regarding the availability of long term care ombudsman services and the telephone number of the local and state long term care ombudsman.

4. Assisted living residency agreements and related documents executed by each resident, resident's representative or resident's legal representative shall be maintained by the operator in files from the date of execution until three years after the agreement is terminated.

The agreements shall be made available for inspection by the commissioner upon request at any time.

* NB There are 2 § 4658's

*** § 4659. Individualized service plan.** 1. A written individualized service plan shall be developed for each resident of an assisted living residence upon admission.

2. The individualized service plan shall be developed with the resident, the resident's representative and resident's legal representative if any, the assisted living operator, and if necessary a home care services agency. The initial individualized service plan shall be developed in consultation with the resident's physician; provided such consultation is documented in writing by the residence. If a resident is determined by his or her physician not to be in need of home care services, the participation of a home care services agency in an evaluation conducted pursuant to this subdivision shall not be necessary.

3. The individualized service plan shall be developed in accordance with the medical, nutritional, rehabilitation, functional, cognitive and other needs of the resident.

4. The individualized service plan shall include the services to be provided, and how and by whom services will be provided and accessed.

5. The individualized service plan shall be reviewed and revised as frequently as necessary to reflect the changing care needs of the resident, but no less frequently than every six months. To the extent necessary, such review and revision shall be undertaken in consultation with the resident's physician.

* NB There are 2 § 4659's

*** § 4660. Rights of residents in assisted living residences.** 1. The principals enunciated in subdivision three of this section are declared

to be the public policy of the state and a copy of such statement of rights and responsibilities shall be posted conspicuously in a public place in each residence covered hereunder.

2. Every assisted living residence shall adopt and make public a statement of the rights and responsibilities of the residents residing in such residence, and shall treat such residents in accordance with the provisions of such statement.

3. Resident's rights and responsibilities shall include, but not be limited to the following:

(a) every resident's participation in assisted living shall be voluntary, and prospective residents shall be provided with sufficient information regarding the residence to make an informed choice regarding participation and acceptance of services;

(b) every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed;

(c) every resident shall have the right to have private communications and consultations with his or her physician, attorney, and any other person;

(d) every resident, resident's representative and resident's legal representative, if any, shall have the right to present grievances on behalf of himself or herself or others, to the residence's staff, administrator or assisted living operator, to governmental officials, to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care;

(e) every resident shall have the right to manage his or her own financial affairs;

(f) every resident shall have the right to have privacy in treatment and in caring for personal needs;

(g) every resident shall have the right to confidentiality in the treatment of personal, social, financial and medical records, and security in storing personal possessions;

(h) every resident shall have the right to receive courteous, fair and respectful care and treatment and a written statement of the services

provided by the residence, including those required to be offered on an as-needed basis;

(i) every resident shall have the right to receive or to send personal mail or any other correspondence without interception or interference by the operator or any person affiliated therewith;

(j) every resident shall have the right not to be coerced or required to perform the work of staff members or contractual work;

(k) every resident shall have the right to have security for any personal possessions if stored by the operator;

(l) every resident shall have the right to receive adequate and appropriate assistance with activities of daily living, to be fully informed of their medical condition and proposed treatment, unless medically contraindicated, and to refuse medication, treatment or services after being fully informed of the consequences of such actions, provided that an operator shall not be held liable or penalized for complying with the refusal of such medication, treatment or services by a resident who has been fully informed of the consequences of such refusal;

(m) every resident and visitor shall have the responsibility to obey all reasonable regulations of the residence and to respect the personal rights and private property of the other residents;

(n) every resident shall have the right to include their signed and witnessed version of the events leading to an accident or incident involving such resident in any report of such accident or incident;

(o) every resident shall have the right to receive visits from family members and other adults of the resident's choosing without interference from the assisted living residence; and

(p) every resident shall have the right to written notice of any fee increase not less than forty-five days prior to the proposed effective date of the fee increase, provided however providing additional services to a resident shall not be considered a fee increase pursuant to this paragraph.

Waiver of any provision contained within this subdivision shall be void;

4. Each assisted living operator shall give a copy of the statement of

rights and responsibilities to each resident at or prior to the time of admission to the residence, the resident's representative and resident's legal representative, if any, and to each member of the residence's staff and any current resident.

* NB There are 2 § 4660's

*** § 4661. Resident funds.** An assisted living operator or employee of a residence or any other entity which is a representative payee of a resident of such residence pursuant to designation by the social security administration or which otherwise assumes management responsibility over the funds of a resident shall maintain such funds in a fiduciary capacity to the resident. Any interest on money received and held for the resident shall be the property of the individual resident.

* NB There are 2 § 4661's

*** § 4662. Powers of the commissioner.** 1. The commissioner is hereby authorized to:

(a) develop, in consultation with the director of the state office for the aging, consumers, operators of assisted living residences and home care service agency providers, a consumer information guide to inform and assist the consumer in the selection of an assisted living residence;

(b) promulgate, in consultation with the director of the state office for the aging, such rules and regulations as are necessary to implement the provisions of this article;

(c) receive and investigate complaints regarding the condition, operation and quality of care of any entities holding themselves out as assisted living, or advertising themselves by a similar term;

(d) make necessary investigations to procure information required to implement the provisions of this article; and

(e) exercise all other powers and functions as are necessary to implement the provisions of this article.

2. Nothing in this section shall restrict the availability of powers otherwise available to the commissioner under the provisions of this

chapter and under the social services law.

* NB There are 2 § 4662's

*** § 4663. Penalties and enforcement.** Any person who violates any provision of this article or any rule or regulation promulgated by the department, or the terms or conditions of any order or permit issued by the department pursuant to this article, shall be subject to the maximum penalties which may be levied against a licensed adult care facility.

* NB There are 2 § 4663's

ARTICLE 47

SHARED HEALTH FACILITIES

- Section 4700. Statement of legislative findings and intent.
4702. Definitions.
4704. Shared health facilities; registration.
4706. Shared health facilities; required notification.
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administrative requirements.
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- 4710-a. Immunizations against poliomyelitis, mumps, measles,
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4716. Construction.
4718. Separability.

§ 4700. Statement of legislative findings and intent. The legislature hereby finds that the provision of health care in shared health care facilities has become an important source of health services in this state and that such facilities are important mechanisms for the delivery of health care services which have largely been created by the funding provisions of the state program of medical assistance for needy persons. The legislature also finds and declares that certain practices exist in the medical assistance program which have resulted in abuses requiring

the regulation of shared health facilities. The legislature further declares it to be the public policy of the state to regulate shared health facilities and to set necessary standards for review of practices and care rendered in those facilities.

§ 4702. Definitions. For the purposes of this article, the following terms shall have the following meanings: 1. "Program" shall mean the New York state program of medical assistance for needy persons, as provided in title XI of article five of the social services law.

2. "Shared health facility" or "facility" means any arrangement wherein four or more practitioners licensed under the provisions of article one hundred thirty-one, one hundred thirty-one-a, one hundred thirty-two, one hundred thirty-three, one hundred thirty-seven, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-six or one hundred fifty-nine of the education law, one or more of whom receives payment under the program and whose total aggregate monthly remuneration from such program is in excess of five thousand dollars for any one month during the preceding twelve months, (a) practice their professions at a common physical location; and (b) share (i) common waiting areas, examining rooms, treatment rooms or other space, or (ii) the services of supporting staff, or (iii) equipment; and (c) a person, whether such person is a practitioner or not, is in charge of, controls, manages or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at said common physical location, other than the direct furnishing of professional services by the practitioners to their patients, or a person makes available to the practitioners the services of supporting staff who are not employees of the practitioners. "Shared health facility" does not mean or include practitioners practicing their profession as a partnership provided that members of the supporting staff are employees of such legal entity and if there is an office manager, or person with similar title, he is an employee of the legal entity whose compensation is customary and not excessive for such services and there is no person described in paragraph (c) of this subdivision. "Shared health facility" does not

mean or include any entity organized pursuant to the provisions of article twenty-eight of this chapter or operating under a certificate issued pursuant to the provisions of article thirteen of the mental hygiene law; nor shall it mean or include a facility wherein ambulatory medical services are provided by an organized group of physicians pursuant to an arrangement between such group and a health services corporation operating under article forty-three of the insurance law or a health maintenance organization operating under article forty-four of the public health law, and where the health services corporation or the health maintenance organization is reimbursed on a prepaid capitation basis for the provision of health care services under New York state's medical assistance program.

3. "Provider" shall mean any qualified physicians, dentists, nurses, optometrists, and other related professional personnel participating in the program.

4. "Purveyor" shall mean any person, who, whether or not located in a building which houses a shared health facility, directly or indirectly, engages in the business of supplying to patients any medical supplies, equipment or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services or supplies; inhalation therapy services or equipment; ambulance services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses, or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment.

5. "Patient" shall mean anyone eligible to receive benefits under the provisions of the program.

§ 4704. Shared health facilities; registration. 1. No shared health facility shall be operated unless the owner of the premises in which the

shared health facility is located or, if the structure in which the shared health facility is located has been leased pursuant to a lease, the lessee, shall:

(a) possess a valid registration issued pursuant to this article which registration may specify the kind or kinds of services the facility is authorized to provide; and

(b) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner.

2. Application for a registration for a shared health facility shall be made upon such forms and at such times as prescribed by the department. The application shall contain:

(i) the name of the facility;

(ii) the kind or kinds of service to be provided;

(iii) the location and physical description of the facility;

(iv) the name and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the facility and the structure in which the facility is located;

(v) the name and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in the shared health facility or in any equipment located in and used in connection with a shared health facility, and a brief description of such lien or security interest;

(vi) the name, residence address and professional license number of every practitioner participating in the shared health facility;

(vii) the name and residence address of the individual designated to assume responsibility for the central coordination and management of the activities of the shared health facility; and

(viii) such other information as the department may require.

3. Any person who operates a shared health facility without a valid registration issued pursuant to this article shall be liable to the people of the state for a civil penalty not to exceed ten thousand dollars for every such violation.

§ 4706. Shared health facilities; required notification. 1. Each operator shall notify the department within fifteen days of any change in:

(a) the persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the shared health facility, or

(b) the persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in the shared health facility or in any equipment located in and used in connection with a shared health facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

2. Each operator shall notify the department within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the activities of the shared health facility, and of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

3. Each operator shall notify the department within fifteen days of any termination of the services of any practitioner in the shared health facility, and of the name, residence address and license number of each practitioner newly participating in the facility.

§ 4708. Shared health facilities; prohibited practices; administrative requirements. With regard to shared health facilities: 1. The rental fee for letting of space to providers in a shared health facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health facility is located. The operator of each facility shall file a copy of each lease and any renewal thereof with the department;

2. No purveyor, whether or not located in a building which houses a shared health facility, shall directly or indirectly offer, pay or give

to any provider, and no provider shall directly or indirectly solicit, request, receive or accept from any purveyor any sum of money, credit or other valuable consideration for:

- (a) recommending or procuring goods, services or equipment of such purveyor, or

- (b) directing patronage or clientele to such purveyor, or

- (c) influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor;

3. No provider or purveyor may demand or collect any compensation in excess of the fee specified in the fee schedule of the program;

4. No purveyor shall provide to a patient eligible to receive benefits under the provisions of the program any services, equipment, pharmaceutical or other medical supplies differing in quantity or in any other respect from that described in the payment invoice submitted by such purveyor to the department. No purveyor shall provide to any patient eligible to receive benefits under the provisions of the program any services, equipment, pharmaceutical or medical supplies differing in quality, quantity or in any other respect from that prescribed by the provider;

5. (a) No provider in a shared health facility or person employed in such facility shall refer a patient to another provider located in such facility unless there is a medical need for such referral and unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

- (b) Every provider practicing in a shared health facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record;

- (c) The invoice submitted to the program by the provider to whom such patient has been referred shall (i) contain the actual signature and provider number of the referring provider and (ii) identify the medical problem which necessitated the referral;

6. Any pharmacy maintaining a business in or adjacent to the building in which a shared health facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the program may be obtained at any pharmacy of the patient's choice enrolled in the program;

7. No purveyor who maintains a business in the building in which a shared health facility is located shall maintain a door or window opening into the offices or waiting room of the facility, except where the profession of the provider permits the provider to function simultaneously as a purveyor;

8. All provider invoices submitted for services rendered at a shared health facility shall: (a) contain the registration code of the facility at which the service was performed, (b) clearly identify the practitioner who provided the service, and (c) be signed by the provider only after the service has been performed;

9. All orders issued by providers for ancillary clinical services, including but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the code number assigned to the facility at which the order was written; and

10. Each provider or purveyor shall submit a true bill or invoice for services rendered in the program.

§ 4710. Shared health facilities; quality of care requirements. 1. To ensure quality, continuity and proper coordination of medical care, each shared health facility shall:

(a) designate an individual who shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this article;

(b) devise an appropriate means of insuring that (i) patients will be scheduled to return for appropriate follow-up care and (ii) will be treated by a practitioner familiar with the patient's medical history;

(c) post conspicuously the names and scheduled office hours of all practitioners practicing in the facility;

(d) maintain proper records which shall contain at least the following information:

(i) the full name, address and program number of each patient;

(ii) the dates of all visits to all providers in the shared health facility;

(iii) the chief complaint for each visit to each provider in the shared health facility;

(iv) pertinent history and all physical examinations rendered by each provider in the shared health facility;

(v) diagnostic impressions for each visit to any provider in the shared health facility;

(vi) all medications prescribed by any provider in the shared health facility;

(vii) the precise dosage and prescription regimens for each medication prescribed by a provider in the shared health facility;

(viii) all x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health facility, and their results;

(ix) all referrals by providers in the shared health facility to other medical practitioners and the reason for such referrals; and

(x) a statement as to whether or not the patient is expected to return for further treatment and the dates of all return appointments;

(e) assign an individual and clearly identified practitioner to all patients. This assignment may be changed at any time at the patient's discretion;

(f) make available to registered patients either:

(i) the central answering service telephone number of each patient's designated practitioner or such practitioner's personally designated colleagues, or

(ii) a centralized twenty-four-hour-a-day, seven-day-weekly telephone line for off-hour emergency patient questions;

(g) maintain a central day-book registry which shall record:

(i) the name and program number of all patients entering the facility; and

(ii) the chief complaint and the names of all providers whose services

were requested by the patient and/or to whom such patient was referred;
and

(h) insure that the physical facilities of each shared health facility shall provide for maximum privacy for all patients during examination, interview and treatment;

(i) post conspicuously the telephone number of the agency within the department of health which is responsible for providing information concerning shared health facilities and/or for receiving complaints concerning the provision of health care services at shared health facilities.

2. It shall be the responsibility of each facility's administrator to ensure that patient records and summaries of all patient visits including diagnosis and pharmaceuticals prescribed are at all times available at either the facility or at a place immediately accessible to all health providers at the facility.

3. Nothing in this article shall in any way be interpreted as infringing upon the patient's right to free selection of a personal practitioner.

4. The department shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health facility. Such inspections may be by site visits to the facility.

§ 4710-a. Immunizations against poliomyelitis, mumps, measles, diphtheria and rubella. 1. It shall be the duty of the individual designated to assume responsibility for the central coordination and management of the activities of the shared health facility to inquire of each person receiving care who is under the age of eighteen, or of a person in parental relation to such person, whether all necessary immunizations have been received for poliomyelitis, mumps, measles, diphtheria and rubella and, if not, to make available such immunizations and a certificate or certificates of such immunizations.

2. This section shall not apply to children whose parent, parents, or guardian are bona fide members of a recognized religious organization whose teachings are contrary to the practices herein required.

3. If any physician licensed to practice medicine in this state certifies that such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization may be found no longer to be detrimental to the child's health.

§ 4712. Shared health facilities; rules and regulations. 1. The department shall have the authority to promulgate rules and regulations relative to the quality of care provided by shared health facilities, and to otherwise effectuate the provisions of this article.

2. (a) Subject to the provisions of paragraphs (b) and (c) of this subdivision and after such hearing the department may suspend or revoke the registration of a shared health facility for failure to comply with any provision of this article applicable to such facility, or for failure to comply with the rules or regulations of the department pertaining thereto, or for fraudulent practices on the part of any of the providers or purveyors therein.

(b) No registration shall be revoked, suspended, limited or annulled without a hearing. However, a registration may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice to the shared health facility following a finding by the department that the public health or safety is in imminent danger.

(c) The commissioner shall fix a time and a place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing shall be served in person or mailed by certified mail to such facility at least twenty-one days before the date fixed for the hearing. The shared health facility shall file with the department not less than eight days prior to the hearing, a written answer to the charges.

(d) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and

rules. Application for such review must be made within sixty days after service in person or by certified mail of a copy of the order or determination upon the applicant.

3. Any provider or purveyor who violates any provision of this article, or of the rules and regulations promulgated pursuant thereto, may, subject to the findings of a hearing or review which he may request of the department, be barred from collecting any payments under the program from the date such violation occurs.

§ 4714. Shared health facilities advisory council. 1. There is hereby created a shared health facilities advisory council consisting of nineteen members appointed by the commissioner for terms of three years. Four of the members shall represent the public interest and shall not be a provider, consumer, or purveyor. Eight of the members shall represent consumers receiving services at shared health facilities, and seven shall be selected from among recommendations made by organizations representing providers and purveyors. Of the members first appointed, seven shall be appointed for terms expiring August thirty-first, nineteen hundred seventy-nine, and six shall be appointed for terms expiring August thirty-first, nineteen hundred seventy-eight. Vacancies shall be filled by appointment for the unexpired terms. The shared health facilities advisory council shall select a chairman from among its members.

2. The shared health facilities advisory council shall meet as frequently as its business may require, but in any event at least three times annually. Meetings may be held at the call of the chairman or the commissioner. The commissioner shall designate an officer or employee of the department to act as secretary of the council. Each member shall be reimbursed for expenses actually and necessarily incurred by him in the performance of his official duties.

3. The shared health facilities advisory council shall have no executive, administrative or appointive duties. It shall have the duty to advise the department on all aspects of shared health facilities

regulation and operation, including the rendering of recommendations concerning proposed department rules and regulations. The shared health facilities advisory council shall perform such other functions as the commissioner may prescribe.

§ 4716. Construction. 1. Nothing herein shall be construed to impair or affect the powers of the department to engage in any of its necessary or proper activities.

2. Notwithstanding any other provision of law, the provisions of article twenty-eight of this chapter shall not be construed to affect or apply to a shared health facility, nor shall the term "hospital service" as used in that article be construed to mean or include services rendered by individual practitioners participating in a shared health facility.

§ 4718. Separability. If any clause, sentence, paragraph, subdivision, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which the judgment shall have been rendered.

ARTICLE 48

TOXIC SUBSTANCES

Section 4800. Applicability.

4801. Definitions.

4802. Powers and duties of the commissioner.

4803. Records and reports.

4804. Outreach programs.

4805. Trade secrets.

4806. Public inquiries.

4808. Separability.

§ 4800. Applicability. It is the purpose of this article to ensure that employees are given information by their employers concerning the nature of toxic substances which they may encounter in the workplace in the course of their employment.

§ 4801. Definitions. When used in this article:

1. "Workplace" means any location away from the home, permanent or temporary, where any employee performs any work-related duty in the course of his employment.

2. "Toxic substance" means any substance which is listed in the latest printed edition of the National Institute for Occupational Safety and Health Registry of Toxic Effects of Chemical Substances or has yielded positive evidence of acute or chronic health hazards in human, animal or other biological testing.

3. "Employer" means any individual, partnership, corporation or association engaged in a business who has employees including the state and its political subdivisions. The term "employer" does not include the employment of domestic workers or casual laborers employed at the place of residence of his or her employer.

§ 4802. Powers and duties of the commissioner. 1. The commissioner or his designated representative from the department shall have the right of entry at reasonable hours into any workplace when the commissioner has reason to believe that employees are being exposed to toxic substances at hazardous levels to conduct such investigations as the commissioner authorizes. The commissioner shall make available to appropriate authorities the results of any such investigation in which hazardous levels of toxic substances are found.

2. The commissioner may make public, available information containing

descriptions of the toxic effects and the circumstances under which these effects are produced for toxic substances found in the course and scope of employment. He shall prepare this information in a clear and coherent manner using words with common and everyday meanings to be forwarded to the industrial commissioner of the department of labor for use in compliance with the provisions of article twenty-eight of the labor law. The information provided may be based on the Threshold Limit Values For Chemical Substances And Physical Agents In The Workroom Environment With Intended Changes For 1979, as amended from time to time, and the current Registry Of Toxic Effects Of Chemical Substances Of The National Institute Of Occupational Safety And Health.

3. The commissioner shall promulgate rules and regulations and take all other actions necessary for the effective implementation of this article.

§ 4803. Records and reports. 1. Upon request by the commissioner, employers shall provide to the commissioner copies of employee health and exposure records maintained and supplied to the federal government by employers as mandated under the following federal statutes and regulations except as access by third parties may be limited therein:

- (a) Toxic Substances Control Act;
- (b) Occupational Safety and Health Act;
- (c) Environmental Pesticide Control Act; and
- (d) Nuclear Regulatory Commission, 10CFR section 20.102-20.409.

2. Upon request by the commissioner employers shall provide the names and addresses of present and former employees whenever the commissioner determines that there is a health risk or disease relating to the exposure of employees to a toxic substance or toxic substances.

3. The commissioner shall not release any information with identifying names. The commissioner may, however, publish analyses of such reports and information from time to time for scientific and public health purposes, in such a manner as to assure that the identities of the individuals concerned cannot be ascertained and that information

protected by applicable trade secret law is not divulged.

4. The commissioner may require an employer to keep records of his employees' use of specific toxic substances when there is scientific evidence to question the efficacy of the current threshold limit values for those substances. Such records shall be held solely for the purpose of conducting epidemiologic research on occupational health.

§ 4804. Outreach programs. 1. The department may develop and implement outreach programs to inform employees of their right to information regarding the toxic effects and circumstances under which these effects are produced by toxic substances found in the course of employment.

2. The department is authorized and empowered to enter into contractual agreements with public and private organizations to develop and implement such an outreach program.

3. As part of the outreach program, health officials may maintain a supply of informational leaflets in public buildings, including but not limited to local employment services offices of the department of labor, institutions and facilities under the supervision or control of the department of health, hospitals, union halls, community centers, schools and local agencies providing services to employers and employees to help insure that such persons are informed of the toxic substance information program. The department shall periodically distribute to newspapers, television and radio stations throughout the state public service announcements describing the toxic substance information outreach program.

4. The department of health shall develop informational leaflets concerning the toxic substance information program in cooperation with the industrial commissioner. The industrial commissioner may mail such leaflets to employers.

§ 4805. Trade secrets. 1. When a manufacturer, producer, formulator or

employer considers the identity of or other information concerning a toxic chemical substance to be a protectable trade secret whose disclosure would compromise his competitive advantage, he may register this information as secret with the commissioner provided that such information is already registered as a trade secret pursuant to any provision of federal law or such information is not registered as a trade secret but is related to a proprietary process the disclosure of which would compromise his competitive position.

2. The commissioner shall not release any data which discloses any trade secret or proprietary process unless he shall notify, in writing and by certified mail, the submitter of such information of the intent to release the data. The commissioner may not release the information, without the submitter's consent, until the thirtieth day after the submitter has been furnished such notice. Any subsequent release shall be pursuant to applicable provisions relating to trade secrets or the Freedom of Information Act.

3. In the event that a substance as to which information is sought is registered as a component of a trade secret or otherwise protected as a proprietary process, the employer, pursuant to procedures established by the commissioner, shall inform employees or their representatives, as to the toxic effects and the circumstances under which these effects are produced for those toxic substances whose identity has been duly registered with the commissioner as a component of a trade secret or a proprietary process but shall not be required to divulge the specific identity of the substance.

4. No officer, employee or agent of any state or municipal department, agency, commission or authority shall disclose to anyone in any manner any record or portions thereof protected pursuant to this article and which are within his custody or knowledge for so long as such record or portions thereof shall be so exempted or until a final judicial denial of such exemption is rendered. Any person who violates any provision of this subdivision may be fined, imprisoned, suspended or removed from office or employment in the manner provided by law.

§ 4806. Public inquiries. Within the limits of any moneys appropriated therefor, the department shall process all inquiries it receives from manufacturers, importers and employers regarding the toxic effects and circumstances under which these effects are produced for toxic substances found in the workplace.

§ 4808. Separability. If any section, clause or provision of this article shall be unconstitutional or be ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be deemed invalid or ineffective.

ARTICLE 49

UTILIZATION REVIEW AND EXTERNAL APPEAL

Title I. Certification of agents and utilization review process
(§§4900-4909).

II. Right to external appeal (§§4910-4917).

TITLE I

CERTIFICATION OF AGENTS AND UTILIZATION REVIEW PROCESS

- Section 4900. Definitions.
4901. Registration of utilization review agents.
4902. Utilization review program standards.
4903. Utilization review determinations.
4904. Appeal of adverse determinations by utilization review agents.
4905. Required and prohibited practices.
4906. Waiver.
4907. Rights and remedies.
4908. Applicability to ERISA Plans.
4909. Site of service clinical review.

§ 4900. Definitions. For purposes of this article:

1. "Adverse determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

2. "Clinical peer reviewer" means:

(a) for purposes of section four thousand nine hundred three of this article:

(i) a physician who possesses a current and valid non-restricted license to practice medicine; or

(ii) a health care professional other than a licensed physician who:

(A) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(B) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; or

* (iii) for purposes of a determination involving substance use disorder treatment:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or

* NB Effective until January 1, 2027

* (iii) for purposes of a determination involving substance-related and addictive disorder treatment:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or

* NB Effective January 1, 2027

(iv) for purposes of a determination involving treatment for a mental health condition:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of a mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(b) for purposes of section four thousand nine hundred four and title two of this article:

(i) a physician who:

(A) possesses a current and valid non-restricted license to practice medicine;

(B) where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(C) for purposes of title two of this article, has been practicing in such area of specialty for a period of at least five years;

* (D) for purposes of a determination involving substance use disorder

treatment, possesses a current and valid non-restricted license to practice medicine and specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment;

* NB Effective until January 1, 2027

* (D) for purposes of a determination involving substance-related and addictive disorder treatment, possesses a current and valid non-restricted license to practice medicine and specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment;

* NB Effective January 1, 2027

(E) for purposes of a determination involving treatment for a mental health condition, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; and

(F) is knowledgeable about the health care service or treatment under appeal; or

(ii) a health care professional other than a licensed physician who:

(A) where applicable, possesses a current and valid non-restricted license, certificate or registration;

(B) where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under appeal;

(C) for purposes of title two of this article, has been practicing in such area of specialty for a period of at least five years;

(D) is knowledgeable about the health care service or treatment under appeal;

* (E) for purposes of a determination involving substance use disorder, specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

* NB Effective until January 1, 2027

* (E) for purposes of a determination involving substance-related and addictive disorder, specializes in behavioral health and has experience in the delivery of substance-related and addictive disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

* NB Effective January 1, 2027

(F) for purposes of a determination involving treatment for a mental health condition, specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(G) where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine.

(c) Nothing in this subdivision shall be construed to change any statutorily-defined scope of practice.

2-a. "Clinical standards" means those guidelines and standards set forth in the utilization review plan by the utilization review agent whose adverse determination is under appeal or, in the case of medically fragile children, those guidelines and standards as required by section forty-four hundred six-i of this chapter.

2-b. "Clinical trial" means a peer-reviewed study plan which has been

(a) reviewed and approved by a qualified institutional review board, and

(b) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional

review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

As used in this subdivision, the term "cooperative groups" means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups; and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups, the NCI Community Clinical Oncology Program (CCOP), the AIDS Clinical Trials Groups (ACTG), and the Community Programs for Clinical Research in AIDS (CPCRA).

* 2-c. "Disabling condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's attending physician, is consistent with the definition of "disabled person" pursuant to subdivision five of section two hundred eight of the social services law.

* NB Effective until January 1, 2027

* (2-c) "Chronic health condition" means a condition that is expected to last for at least one year and requires ongoing treatment to effectively manage the condition or prevent an adverse health event.

* NB Effective January 1, 2027

* 2-d. "Disabling condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's attending physician, is consistent with the definition of "disabled person" pursuant to subdivision five of section two hundred eight of the social services law.

* NB Effective January 1, 2027

3. "Emergency condition" means a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily

functions; (c) serious dysfunction of any bodily organ or part of such person; (d) serious disfigurement of such person; or (e) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

4. "Enrollee" means a person subject to utilization review.

4-a. "Experimental and investigational treatment review plan" means:

(a) a description of the process for developing the written clinical review criteria used in rendering an experimental and investigational treatment review determination; and

(b) a description of the qualifications and experience of the clinical peers who developed the criteria, who are responsible for periodic evaluation of the criteria, and who use the written clinical review criteria in the process of reviewing proposed experimental and investigational health services and procedures.

4-b. "External appeal" means an appeal conducted by an external appeal agent in accordance with the provisions of section forty-nine hundred fourteen of this article.

4-c. "External appeal agent" means an entity certified by the commissioner pursuant to section forty-nine hundred eleven of this article.

4-d. "Final adverse determination" means an adverse determination which has been upheld by a utilization review agent with respect to a proposed health care service following a standard appeal, or an expedited appeal where applicable, pursuant to section forty-nine hundred four of this title.

4-e. "Health care plan" means any organization certified under article forty-four of this chapter.

5. (a) For purposes of this title and for appeals requested pursuant to paragraph (a) of subdivision two of section forty-nine hundred ten of title two of this article, "health care service" means:

(i) health care procedures, treatments or services

(A) provided by a facility licensed pursuant to article twenty-eight, thirty-six, forty-four or forty-seven of this chapter or pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law; or

(B) provided by a health care professional; and

(ii) the provision of pharmaceutical products or services or durable medical equipment.

(b) For purposes of appeals requested pursuant to paragraph (b) of subdivision two of section forty-nine hundred ten of title two of this article, "health care services" shall mean experimental or investigational procedures, treatments or services, including:

(A) services provided within a clinical trial, and

(B) the provision of a pharmaceutical product pursuant to prescription by the enrollee's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the federal Food and Drug Administration; to the extent that coverage for such services are prohibited by law from being excluded under the plan.

Provided that nothing in this subdivision shall be construed to define what are covered services pursuant to a subscriber contract or governmental health benefit program.

6. "Health care professional" means an appropriately licensed, registered or certified health care professional pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

7. "Health care provider" means a health care professional or a facility licensed pursuant to articles twenty-eight, thirty-six, forty-four or forty-seven of this chapter or a facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law.

7-a. "Life-threatening condition or disease" means a condition or disease which, according to the current diagnosis of the enrollee's

attending physician, has a high probability of causing the enrollee's death.

7-b. "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

7-c. "Material financial affiliation" means any financial interest of more than five percent of total annual revenue or total annual income of an external appeal agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any external appeal. The term "material financial affiliation" shall not include revenue received from a health care plan by (a) an external appeal agent to conduct an external appeal pursuant to section forty-nine hundred fourteen of title two of this article, or (b) a clinical peer reviewer for health services rendered to enrollees.

7-d. "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent organization.

7-e. "Medical and scientific evidence" means the following sources:

(a) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline and MEDLARS database Health Services Technology Assessment Research;

(c) peer-reviewed abstracts accepted for presentation at major medical

association meetings;

(d) peer-reviewed literature shall not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer;

(e) medical journals recognized by the secretary of Health and Human Services, under section 1861 (t)(2) of the federal Social Security Act;

(f) the following standard reference compendia:

(i) the American Hospital Formulary Service - Drug Information;

(ii) the American Medical Association Drug Evaluation;

(iii) the American Dental Association Accepted Dental Therapeutics;
and

(iv) the United States Pharmacopeia - Drug Information;

(g) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

7-f. "Out-of-network denial" means a denial of a request for pre-authorization to receive a particular health service from an out-of-network provider on the basis that such out-of-network health service is not materially different than the health service available in-network. The notice of an out-of-network denial provided to an enrollee shall include information explaining what information the enrollee must submit in order to appeal the out-of-network denial pursuant to subdivision one-a of section four thousand nine hundred four of this article. An out-of-network denial under this subdivision does not constitute an adverse determination as defined in this article. Notwithstanding any other provision of this subdivision, an out-of-network denial shall not be construed to include a denial for a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by the enrollee.

7-f-1. "Out-of-network referral denial" means a denial of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an enrollee, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an enrollee shall include information explaining what information the enrollee must submit in order to appeal the out-of-network referral denial pursuant to subdivision one-b of section four thousand nine hundred four of this article. An out-of-network referral denial under this subdivision does not constitute an adverse determination as defined in this article. An out-of-network referral denial shall not be construed to include an out-of-network denial as defined in subdivision seven-f of this section.

7-f-2. "Step therapy protocol override determination" means a determination made by a utilization review agent as defined in subdivision nine of this section to override a step therapy protocol pursuant to subdivisions three-a, three-b and three-c of section forty-nine hundred three of this title granting coverage for the health care professional's selected prescription drug or drugs. Any step therapy protocol override determination as defined by this subdivision shall be eligible for appeal by an enrollee pursuant to this article.

7-f-3. "Step therapy protocol" means a policy, protocol or program established by a utilization review agent as defined in subdivision nine of this section that establishes the specific sequence in which prescription drugs for a specified medical condition are approved for a particular enrollee. Nothing in this chapter shall impair or prevent an insured from having the right to appeal pursuant to this article relating to the imposition of a step therapy protocol.

7-g. "Rare disease" means a condition or disease that (1)(A) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or (B) affects fewer than two hundred thousand United States residents per year, and (2) for which there does not exist a standard health service

or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the enrollee's treating physician, shall certify in writing that the condition is a rare disease as defined in this subsection. The certifying physician shall be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the enrollee's rare disease. The certification shall provide either: (1) that the insured's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (2) that the insured's rare disease affects fewer than two hundred thousand United States residents per year. The certification shall rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the enrollee than the requested health service or procedure and the requested health service or procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure. The certifying physician shall disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of denial of a rare disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, an enrollee or enrollee's designee shall also submit such approval as part of the external appeal application.

8. "Utilization review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purposes of this article none of the following shall be considered utilization review:

(a) Denials based on failure to obtain health care services from a designated or approved health care provider as required under a

subscriber's contract;

(b) Where any determination is rendered pursuant to subdivision three-a of section twenty-eight hundred seven-c of this chapter;

(c) The review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure;

(d) Any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination; and

(e) Any determination of any coverage issues other than whether health care services are or were medically necessary.

9. "Utilization review agent" means any company, organization or other entity performing utilization review, except:

(a) an agency of the federal government;

(b) an agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government;

(c) an agent acting on behalf of the state and local government for services provided pursuant to title XIX of the federal social security act;

(d) a hospital's internal quality assurance program except if associated with a health care financing mechanism; or

(e) any insurer subject to article thirty-two or forty-three of the insurance law and any independent utilization review agent performing utilization review under a contract with such insurer, which shall be subject to article forty-nine of the insurance law.

10. "Utilization review plan" means:

(a) a description of the process for developing the written clinical review criteria;

(b) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to, a set of specific written clinical review criteria;

(c) a description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity, which in the case of medically fragile children shall

incorporate the standards required by section forty-four hundred six-i of this chapter;

(d) the procedures for scheduled review and evaluation of the written clinical review criteria; and

(e) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of utilization review.

§ 4901. Registration of utilization review agents. 1. Every utilization review agent who conducts the practice of utilization review shall biennially register with the commissioner and report, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subdivision two of this section.

2. Such report shall contain a description of the following:

(a) The utilization review plan;

(b) Those circumstances, if any, under which utilization review may be delegated to a utilization review program conducted by a facility licensed pursuant to article twenty-eight of this chapter or pursuant to article thirty-one of the mental hygiene law;

(c) The provisions by which an enrollee, the enrollee's designee, or a health care provider may seek reconsideration of, or appeal from, adverse determinations by the utilization review agent, in accordance with the provisions of this title, including provisions to ensure a timely appeal and that an enrollee, the enrollee's designee, and, in the case of an adverse determination involving a retrospective determination, the enrollee's health care provider, is informed of their right to appeal adverse determinations;

(d) Procedures by which a decision on a request for utilization review for services requiring preauthorization shall comply with timeframes established pursuant to this title;

(e) A description of an emergency care policy, which shall include the procedures under which an emergency admission shall be made or emergency

treatment shall be given;

(f) A description of the personnel utilized to conduct utilization review including a description of the circumstances under which utilization review may be conducted by:

(i) administrative personnel,

(ii) health care professionals who are not clinical peer reviewers, and

(iii) clinical peer reviewers;

(g) A description of the mechanisms employed to assure that administrative personnel are trained in the principles and procedures of intake screening and data collection and are appropriately monitored by a licensed health care professional while performing an administrative review;

(h) A description of the mechanisms employed to assure that health care professionals conducting utilization review are:

(i) appropriately licensed, registered or certified; and

(ii) trained in the principles, procedures and standards of such utilization review agent;

(i) A description of the mechanisms employed to assure that only a clinical peer reviewer shall render an adverse determination;

(j) Provisions to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not later than the next business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subdivision three of section forty-nine hundred three of this title or an expedited appeal filed pursuant to subdivision two of section forty-nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(k) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical and treatment records are followed;

(l) A copy of the materials to be disclosed to an enrollee or prospective enrollee pursuant to this title and section forty-four hundred eight of this chapter;

(m) A description of the mechanisms employed by the utilization review agent to assure that all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent will adhere to the standards and requirements of this title; and

(n) A list of the payors for which the utilization review agent is performing utilization review in this state.

3. Upon receipt of the report, the commissioner shall issue an acknowledgment of the filing.

4. A registration issued under this title shall be valid for a period of not more than two years, and may be renewed for additional periods of not more than two years each.

5. A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified under article forty-four of this chapter shall not be required to register as a utilization review agent, provided that such health maintenance organization has otherwise provided the information required pursuant to subdivision two of this section to the commissioner.

6. The clinical review criteria and standards contained within the utilization review plan and the list of payors required pursuant to paragraph (n) of subdivision two of this section shall not be subject to disclosure pursuant to the provisions of article six of the public officers law.

§ 4902. Utilization review program standards. 1. Each utilization review agent shall adhere to utilization review program standards

consistent with the provisions of this title which shall, at a minimum, include:

(a) Appointment of a medical director, who is a licensed physician; provided, however, that the utilization review agent may appoint a clinical director when the utilization review performed is for a discrete category of health care service and provided further that the clinical director is a licensed health care professional who typically manages the category of service. Responsibilities of the medical director, or, where appropriate, the clinical director, shall include, but not be limited to, the supervision and oversight of the utilization review process;

(b) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to enrollees and health care providers a written description of such procedures including procedures to appeal an adverse determination together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such appeals;

(c) Utilization of written clinical review criteria developed pursuant to a utilization review plan;

(d) Establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization reviews and determinations are conducted within the timeframes established herein; procedures to notify an enrollee, an enrollee's designee and/or an enrollee's health care provider of adverse determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the enrollee;

(e) (i) Establishment of a written procedure to assure that the notice of an adverse determination includes: (1) the reasons for the determination including the clinical rationale, if any; (2) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section

forty-nine hundred fourteen of this article; (3) notice of the availability, upon request of the enrollee or the enrollee's designee, of the clinical review criteria relied upon to make such determination; (4) what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on an appeal; and (5) for an adverse determination related to a step therapy protocol override determination, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the utilization review agent.

(ii) A utilization review agent may provide notice of an adverse determination related to a step therapy protocol override determination electronically pursuant to subdivision nine of section forty-nine hundred three of this title, including by electronic mail or through the health care plan's member portal and provider portal. An electronic notice of such an adverse determination may meet the requirements of clause five of subparagraph (i) of this paragraph by linking to information posted on the website of the health care plan;

(f) Establishment of a requirement that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:

(i) not less than forty hours per week during normal business hours to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subdivision three of section forty-nine hundred three of this title or an expedited appeal filed pursuant to subdivision two of section forty-nine hundred four of this title, on a twenty-four hour a day, seven day a week basis;

(g) Establishment of appropriate policies and procedures to ensure

that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(h) Establishment of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization nor shall reimbursement for such services be denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.

* (i) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

* NB Effective until January 1, 2027

* (i) When conducting utilization review for purposes of determining health care coverage for substance-related and addictive disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of addiction services and supports that is consistent with the treatment service levels within the office of addiction services and supports system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

* NB Effective January 1, 2027

(j) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental

health, in consultation with the commissioner and the superintendent of financial services. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

(k) Establishment of a requirement that emergency department and inpatient hospital services rendered by a general hospital certified pursuant to article twenty-eight of this chapter to an enrollee to treat COVID-19 during a declared state disaster emergency related to COVID-19 shall not be denied on retrospective review on the basis that such services were not medically necessary.

(l) The commissioner, in consultation with the superintendent of financial services, may, as necessary, promulgate by regulation special considerations and processes for utilization review related to medically fragile children. Such regulations may include, at a minimum, considerations and processes related to:

(i) medically necessary covered services to medically fragile children;

(ii) determinations specific to the needs of medically fragile children;

(iii) stabilization and discharge plans; and

(iv) payment for the care of medically fragile children.

2. Each utilization review agent shall assure adherence to the requirements stated in subdivision one of this section by all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent.

3. When establishing a step therapy protocol, a utilization review agent shall utilize recognized evidence-based and peer reviewed clinical review criteria that takes into account the needs of atypical patient populations and diagnoses as well when establishing the clinical review criteria.

4. When conducting utilization review for a step therapy protocol override determination, a utilization review agent shall utilize, in addition to any other requirements of this article, recognized evidence-based and peer reviewed clinical review criteria that is

appropriate for the enrollee and the enrollee's medical condition.

5. When establishing a step therapy protocol, a utilization review agent shall ensure that the protocol cannot:

(a) require a prescription drug that has not been approved by the United States Food and Drug Administration for the medical condition being treated or is not supported by current evidence-based guidelines for the medical condition being treated;

(b) require an enrollee to try and fail on more than two drugs used to treat the same medical condition or disease before providing coverage to the enrollee for the prescribed drug;

(c) require the use of a step therapy-required drug for longer than thirty days or a duration of treatment supported by current evidence-based treatment guidelines appropriate to the specific disease state being treated;

(d) be imposed on an enrollee if a therapeutic equivalent to the prescribed drug is not available; or if the health care plan has documentation that it has covered the drug for the enrollee within the past three hundred sixty-five days;

(e) require a newly enrolled enrollee to repeat a step therapy protocol for a prescribed drug where that enrollee already completed a step therapy protocol for that drug under a prior health care plan, so long as the enrollee or provider submits information demonstrating completion of a step therapy protocol of the prior health care plan within the past three hundred sixty-five days; and

(f) be imposed on an enrollee for a prescribed drug that was previously approved for coverage by the enrollee's current health care plan for the enrollee's specific medical condition after the enrollee's current health care plan implements a formulary or utilization management change that impacts the coverage criteria for the prescribed drug until the approved override expires, unless a specifically identified and evidence-based safety concern exists and a different therapeutic alternative drug exists.

6. When establishing a step therapy protocol, a utilization review agent shall ensure that the protocol accepts any written or electronic attestation submitted by the enrollee's health care professional, as

defined in section forty-nine hundred of this title, who prescribed the drug and stating that a required drug has failed, as evidence that the required drug has failed.

§ 4903. Utilization review determinations. 1. Utilization review shall be conducted by:

(a) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided, however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;

(b) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and

(c) A clinical peer reviewer where the review involves an adverse determination.

2. (a) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information, or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify; (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services

and the usual and customary cost for out-of-network health care services.

* (b) With regard to individual or group contracts authorized pursuant to article forty-four of this chapter, for utilization review determinations involving proposed mental health and/or substance use disorder services where the enrollee or the enrollee's designee has, in a format prescribed by the superintendent of financial services, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the enrollee or the enrollee's designee by telephone within seventy-two hours of receipt of the request. Written notice of the determination to the enrollee or enrollee's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective until January 1, 2027

* (b) With regard to individual or group contracts authorized pursuant to article forty-four of this chapter, for utilization review determinations involving proposed mental health and/or substance-related and addictive disorder services where the enrollee or the enrollee's designee has, in a format prescribed by the superintendent of financial services, certified in the request that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the utilization review agent shall make a determination and provide notice of such determination to the enrollee or the enrollee's designee by telephone within seventy-two hours of receipt of the request. Written notice of the determination to the enrollee or enrollee's designee shall follow within three business days. Where feasible, such telephonic and written notice shall also be provided to the court.

* NB Effective January 1, 2027

* 3. (a) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment

prescribed by a health care provider, or requests for inpatient substance use disorder treatment, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance use disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(b) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(c) Provided that a request for inpatient treatment for substance use disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance use disorder treatment while a determination by the utilization review agent is pending.

* NB Effective until January 1, 2027

* 3. (a) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or requests for inpatient substance-related and addictive disorder treatment, or home health care services following an inpatient hospital admission, and shall provide

notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance-related and addictive disorder treatment, within twenty-four hours of receipt of the request for services when the request is submitted at least twenty-four hours prior to discharge from an inpatient admission. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(b) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(c) Provided that a request for inpatient treatment for substance-related and addictive disorder is submitted to the utilization review agent at least twenty-four hours prior to discharge from an inpatient admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for the inpatient substance-related and addictive disorder treatment while a determination by the utilization review agent is pending.

* NB Effective January 1, 2027

3-a. A utilization review agent shall grant a step therapy protocol override determination within seventy-two hours of the receipt of information that includes supporting rationale and documentation from a health care professional which demonstrates that:

(a) The required prescription drug or drugs is contraindicated, will likely cause an adverse reaction by or physical or mental harm to the

enrollee;

(b) The required prescription drug or drugs is expected to be ineffective based on the known clinical history and conditions of the enrollee and the enrollee's prescription drug regimen;

(c) The enrollee has tried the required prescription drug or drugs while under their current or a previous health insurance or health benefit plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action and such prescription drug or drugs was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(d) The enrollee is stable on a prescription drug or drugs selected by their health care professional for the medical condition under consideration, provided that this shall not prevent a utilization review agent from requiring an insured to try an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug or drugs; or

(e) The required prescription drug or drugs is not in the best interest of the enrollee because it will likely cause a significant barrier to the enrollee's adherence to or compliance with the enrollee's plan of care, will likely worsen a comorbid condition of the enrollee, or will likely decrease the covered enrollee's ability to achieve or maintain reasonable functional ability in performing daily activities.

3-b. For an enrollee with a medical condition that places the health of the insured in serious jeopardy without the prescription drug or drugs prescribed by the insured's health care professional, the step therapy protocol override determination shall be granted within twenty-four hours of the receipt of information that includes supporting rationale and documentation from a health care professional demonstrating one or more of the standards provided for in subdivision three-a of this section.

3-c. Upon a determination that the step therapy protocol should be overridden, the health care plan shall authorize immediate coverage for the prescription drug or drugs prescribed by the enrollee's treating health care professional. Any approval of a step therapy protocol override determination request shall be honored until the lesser of

either treatment duration based on current evidence-based treatment guidelines or twelve months following the date of the approval of the request or renewal of the enrollee's coverage.

4. A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information.

5. (a) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:

(i) the reasons for the determination including the clinical rationale, if any;

(ii) instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article;

(iii) notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal; and

(iv) for an adverse determination related to a step therapy protocol override request, information that includes the clinical review criteria relied upon to make such determination and any applicable alternative prescription drugs subject to the step therapy protocol of the utilization review agent.

(b) A utilization review agent may provide notice of an adverse determination related to a step therapy protocol override determination electronically pursuant to subdivision nine of this section, including by electronic mail or through the health care plan's member portal and provider portal. An electronic notice of such an adverse determination may meet the requirements of subparagraph (iv) of paragraph (a) of this subdivision by linking to information posted on the website of the health care plan.

6. In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the

enrollee's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one business day of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, the utilization review agent shall provide notice as required pursuant to subdivision five of this section. Nothing in this section shall preclude the enrollee from initiating an appeal from an adverse determination.

7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to section forty-nine hundred four of this title, provided, however, that failure to meet such time periods for a step therapy protocol as defined in subdivision seven-f-three of section forty-nine hundred of this title or a step therapy protocol override determination pursuant to subdivisions three-a, three-b and three-c of this section shall be deemed to be an override of the step therapy protocol. A utilization review agent's failure to comply with any of the step therapy protocol requirements required in subdivisions five and six of section forty-nine hundred two of this title shall be considered a basis for granting an override of the step therapy protocol, absent fraud.

8. The commissioner, in conjunction with the superintendent of financial services, shall develop standards for prior authorization requests to be utilized by all health care plans for the purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits under this article. The department and the department of financial services, in development of the standards, shall take into consideration existing electronic prior authorization standards including National Council for Prescription Drug Programs (NCPDP) electronic prior authorization standard transactions.

9. A utilization review agent shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of preference to receive such notifications by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. To the extent practicable, such written and telephone notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the commissioner upon request.

§ 4904. Appeal of adverse determinations by utilization review agents.

1. An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider, may appeal an adverse determination rendered by a utilization review agent.

1-a. An enrollee or the enrollee's designee may appeal an out-of-network denial by a health care plan by submitting: (a) a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and (b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the enrollee than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased

over the in-network health service.

1-b. An enrollee or the enrollee's designee may appeal a denial of an out-of-network referral by a health care plan by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, provided that: (a) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service; and (b) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this title; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination; or

* (c) potential court-ordered mental health and/or substance use disorder services pursuant to paragraph (b) of subdivision two of section forty-nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance use

disorder treatment provided pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. Provided that the enrollee or the enrollee's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance use disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance use disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective until January 1, 2027

* (c) potential court-ordered mental health and/or substance-related and addictive disorder services pursuant to paragraph (b) of subdivision two of section forty-nine hundred three of this title. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal except, with respect to inpatient substance-related and addictive disorder treatment provided pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, expedited appeals shall be determined within twenty-four hours of receipt of such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. Provided that

the enrollee or the enrollee's health care provider files an expedited internal and external appeal within twenty-four hours from receipt of an adverse determination for inpatient substance-related and addictive disorder treatment for which coverage was provided while the initial utilization review determination was pending pursuant to paragraph (c) of subdivision three of section forty-nine hundred three of this title, a utilization review agent shall not deny on the basis of medical necessity or lack of prior authorization such substance-related and addictive disorder treatment while a determination by the utilization review agent or external appeal agent is pending.

* NB Effective January 1, 2027

3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within fifteen days of such filing and shall make a determination with regard to the appeal within thirty days of the receipt of necessary information to conduct the appeal and, upon overturning the adverse determination, shall comply with subsection (a) of section three thousand two hundred twenty-four-a of the insurance law as applicable. The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within two business days of the rendering of such determination. The notice of the appeal determination shall include:

(a) the reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and

(b) a notice of the enrollee's right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this

article and the time frames for such external appeals. A utilization review agent shall have procedures for obtaining an enrollee's, or enrollee's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the commissioner. Written and telephone notification to an enrollee or the enrollee's designee under this section may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of a preference to receive such notifications by electronic means. An organization shall permit the enrollee and the enrollee's designee to change the preference at any time. To the extent practicable, written and telephone notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The utilization review agent shall retain documentation of preferred notification methods and present such records to the commissioner upon request.

4. Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

5. Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

§ 4905. Required and prohibited practices. 1. Each utilization review agent shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(a) kept confidential in accordance with applicable state and federal laws; and

(b) shared only with the enrollee, the enrollee's designee, the enrollee's health care provider and those who are authorized by law to receive such information.

2. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients.

3. Any health care professional who makes determinations regarding the medical necessity of health care services during the course of utilization review shall be appropriately licensed, registered or certified.

4. A utilization review agent shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

(a) either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

(b) any other method that encourages the rendering of an adverse determination.

5. If a health care service has been specifically pre-authorized or approved for an enrollee by a utilization review agent, a utilization review agent shall not, pursuant to retrospective review, revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the enrollee during the same course of treatment.

* 6. Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary.

* NB Effective until January 1, 2027

* 6. Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary provided, however, that utilization review shall not be conducted more than once per year for an outpatient course of treatment for a chronic health condition starting from the date of a pre-authorization approval for the course of treatment unless the enrollee's attending provider recommends a change to the course of treatment, then utilization review may be conducted for the new course of treatment. Any new treatment, testing or procedures related to the specific medical problem, condition, or illness being managed but not already included in the approved course of treatment may be subject to a separate pre-authorization.

* NB Effective January 1, 2027

7. When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively.

8. In no event shall information be obtained from the health care providers for the use of the utilization review agent by persons other than health care professionals, medical record technologists or administrative personnel who have received appropriate training.

9. The utilization review agent shall not undertake utilization review at the site of the provision of health care services unless the utilization review agent:

(a) Identifies himself or herself by name and the name of his or her organization, including displaying photographic identification which includes the name of the utilization review agent and clearly identifies the individual as representative of the utilization review agent;

(b) Whenever possible, schedules review at least one business day in advance with the appropriate health care provider;

(c) If requested by a health care provider, assures that the on-site review staff register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from the health care provider;

(d) Obtains consent from the enrollee or the enrollee's designee before interviewing the patient's family, or observing any health care service being provided to the enrollee; and

(e) This subdivision shall not apply to health care professionals

engaged in providing care, case management or making on-site discharge decisions.

10. A utilization review agent shall not base an adverse determination on a refusal to consent to observing any health care service.

11. A utilization review agent shall not base an adverse determination on lack of reasonable access to a health care provider's medical or treatment records unless the utilization review agent has provided reasonable notice to the enrollee, the enrollee's designee or the enrollee's health care provider, in which case the enrollee must be notified, and has complied with all provisions of subdivision nine of this section.

12. Neither the utilization review agent nor the entity for which the agent provides utilization review shall take any action with respect to a patient or a health care provider that is intended to penalize such enrollee, the enrollee's designee, or the enrollee's health care provider for, or to discourage such enrollee, the enrollee's designee, or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination.

13. In no event shall an enrollee, an enrollee's designee, an enrollee's health care provider, any other health care provider, or any other person or entity, be required to inform or contact the utilization review agent prior to the provision of emergency care, including emergency treatment or emergency admission.

14. No contract or agreement between a utilization review agent and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the utilization review agent as opposed to the health care provider.

15. A health care professional providing health care services to an enrollee shall be prohibited from serving as the clinical peer reviewer for such enrollee in connection with the health care services being

provided to the enrollee.

§ 4906. Waiver. 1. Any agreement which purports to waive, limit, disclaim, or in any way diminish the rights set forth in this article, except as provided pursuant to section four thousand nine hundred ten of this article shall be void as contrary to public policy.

2. Notwithstanding subdivision one of this section, in lieu of the external appeal process as set forth in this article, a health care plan and a facility licensed pursuant to article twenty-eight of this chapter may agree to an alternative dispute resolution mechanism to resolve disputes otherwise subject to this article.

§ 4907. Rights and remedies. The rights and remedies conferred in this article upon enrollees and health care providers shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.

§ 4908. Applicability to ERISA Plans. Notwithstanding the foregoing, the provisions of this article shall not apply to any utilization review conducted by, or on behalf of, a self-insured employee welfare benefit plan, as defined in the employee retirement income security act of 1974, as amended.

§ 4909. Site of service clinical review. 1. For purposes of this section:

(a) "Free-standing ambulatory surgical center" shall mean a diagnostic and treatment center authorized pursuant to article twenty-eight of this chapter and operated independently from a hospital.

(b) "Health care plan" shall mean an insurer, a corporation organized pursuant to article forty-three of the insurance law, a health maintenance organization certified pursuant to article forty-four of this chapter, a municipal cooperative health benefit plan certified

pursuant to article forty-seven of the insurance law, and a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law, that issues a health insurance policy or contract or that arranges for care and services for members under a contract with the department with a network of health care providers and utilizes site of service clinical review to determine coverage for services delivered by network participating providers.

(c) "Hospital-based outpatient clinic" shall mean a clinic authorized pursuant to article twenty-eight of this chapter and listed on a hospital's operating certificate.

(d) "Site of service clinical review" shall mean clinical criteria applied by a health care plan for the purpose of determining whether non-urgent outpatient medical procedures and surgeries will be covered for a given insured or enrollee when rendered by a network participating provider at a hospital-based outpatient clinic rather than a free-standing ambulatory surgical center.

2. Site of service clinical review shall be deemed utilization review in accordance with and subject to the requirements and protections of this article and article forty-nine of the insurance law, including the right to internal and external appeal of denials related to site of service clinical review.

3. Site of service clinical review shall consider the insured's health and safety, choice of health care provider, and timely access to care and shall not be based solely on cost.

4. A health care plan that utilizes site of service clinical review that is intended to direct insureds and enrollees to free-standing ambulatory surgical centers shall be able to demonstrate to the department that it has an adequate network of free-standing ambulatory surgical center providers to meet the health needs of insureds and enrollees and to provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. Such network shall be in compliance with network adequacy standards established by the commissioner and article forty-four of this chapter.

5. Except as provided in subdivision seven of this section, starting January first, two thousand twenty-four, a health care plan that utilizes a site of service clinical review shall deliver a notice disclosing and clearly explaining the site of service clinical review to:

(a) policyholders, contract holders, insureds, and enrollees and prospective policyholders, contract holders, insureds, and enrollees at the time of plan and policy or contract selection and at least ninety days prior to the implementation of new site of service clinical review or modification of existing site of service clinical review. Such notice shall include the specific services under the site of service review policy, a statement that site of service clinical review may limit the settings in which services covered under the policy or contract may be provided and render a network participating provider unable to perform a service; shall disclose to insureds or enrollees any quality or cost differential, including differences in out-of-pocket costs, between the hospital-based outpatient clinic and the free-standing ambulatory surgical center when services at a hospital-based outpatient clinic are requested; and shall set forth any rights the insured or enrollee may have to obtain the service at a hospital-based outpatient clinic through a utilization review appeal. Notifications shall also be made at any other time upon the insured's or enrollee's request;

(b) network participating providers at least ninety days prior to implementation. A health care plan shall also inform providers of the process for requesting coverage of a service in a hospital-based outpatient clinic setting, including the right to request a real time clinical peer to peer discussion as part of the authorization process; and

(c) the commissioner, at least forty-five days prior to notifying policyholders, contract holders, insureds and enrollees and prospective policyholders, contract holders, insureds and enrollees and network participating providers in accordance with this subdivision. Such notice to the commissioner shall include (i) draft communications to the foregoing persons for purposes of complying with this subdivision and (ii) an explanation of how the site of service clinical review selected by the health care plan complies with this article and article forty-nine of the insurance law.

6. A health care plan's provider directory shall explain that even though a provider is participating in the network, a site of service clinical review may affect where services will need to be obtained and whether the provider will be available to provide such service, as applicable.

7. A health care plan that has implemented site of service clinical review prior to January first, two thousand twenty-four that is not in compliance with this section shall revise such site of service clinical review to comply with this section and deliver the notices required under subdivision five of this section at the beginning of the open enrollment period for individual health insurance policies and contracts, and for group health insurance policies and contracts, prior to January first, two thousand twenty-four.

8. Starting January first, two thousand twenty-four, at a minimum, a health care plan shall approve a request for authorization for a service covered under the policy or contract and requested to be performed by a network participating provider at a hospital-based outpatient clinic in the following situations:

(a) the procedure cannot be safely performed in a free-standing ambulatory surgical center due to the insured's or enrollee's health condition;

(b) there is no free-standing ambulatory surgical center capacity in the insured's or enrollee's geographic area; or

(c) the provision of health care services at a free-standing ambulatory surgical center would result in undue delay.

9. Starting January first, two thousand twenty-four, site of service clinical review criteria developed by health care plans shall also take into consideration whether:

(a) the insured's or enrollee's treating network participating provider recommends, based on a written clinical justification submitted to the health care plan, that the service be provided at a hospital-based outpatient clinic; or

(b) the insured or enrollee has requested a particular network

participating provider who performs the requested service in a hospital-based outpatient clinic because the insured or enrollee is undergoing a continuing course of treatment with the participating provider or because the insured has previously obtained the requested service from the participating provider, and the provider is not credentialed at any free-standing ambulatory surgical center in the service area and is not able to be credentialed within ninety days following the submission of the authorization request to the health care plan.

TITLE II

RIGHT TO EXTERNAL APPEAL

Section 4910. Right to external appeal established.

4911. Powers of the commissioner.

4912. Standards for certification.

4913. Conflict of interest.

4914. Procedures for external appeals of adverse determinations.

4915. Prohibited practices.

4916. Oversight and surveillance of the external appeal process.

4917. Hold harmless.

§ 4910. Right to external appeal established. 1. There is hereby established an enrollee's right to an external appeal of a final adverse determination by a health care plan.

2. An enrollee, the enrollee's designee and, in connection with concurrent and retrospective adverse determinations, an enrollee's health care provider, shall have the right to request an external appeal when:

(a) (i) the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan's requirements for medical necessity, appropriateness, health care setting, level of

care, effectiveness of a covered benefit, or other ground consistent with 42 U.S.C. § 300gg-19 as determined by the commissioner in consultation with the superintendent of financial services, and

(ii) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the enrollee have jointly agreed to waive any internal appeal, or the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19; or

(b) (i) the enrollee has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under title one of this article, or both the plan and the enrollee have jointly agreed to waive any internal appeal, or the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the federal Public Health Service Act, 42 U.S.C. § 300gg-19, and

(ii) the enrollee's attending physician has certified that the enrollee has a condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial or rare disease treatment, and

(iii) the enrollee's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph (b) of subdivision five of section forty-nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subdivision seven-g of section forty-nine hundred of this article and such other evidence as the enrollee, the enrollee's designee or the enrollee's attending physician may present, that the requested health service or procedure is likely to benefit the enrollee in the treatment

of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure; or (b) a clinical trial for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

(iv) the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational; or

(c)(i) the enrollee has had coverage of the health service (other than a clinical trial to which paragraph (b) of this subdivision shall apply), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health service is out-of-network and an alternate recommended health service is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial or both the health plan and the enrollee have jointly agreed to waive any internal appeal; and

(ii) the enrollee's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network service, and recommends a health care service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

(d)(i) The enrollee has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an enrollee, and who is able to provide the requested health service.

(ii) The enrollee's attending physician, who shall be a licensed,

board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought, certifies that the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of an enrollee, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an enrollee, and who is able to provide the requested health service.

3. (a) The health care plan may charge the enrollee a fee of up to twenty-five dollars per external appeal with an annual limit on filing fees for an enrollee not to exceed seventy-five dollars within a single plan year; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the enrollee. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if the enrollee is a recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of this chapter. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if such fee shall pose a hardship to the enrollee as determined by the plan.

(b) The health care plan may charge the enrollee's health care provider a fee of up to fifty dollars per external appeal, other than for an external appeal requested pursuant to paragraph (b) or (c) of subdivision four of section forty-nine hundred fourteen of this article; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the enrollee's health care provider.

4. An enrollee covered under the Medicare or Medicaid program may appeal the denial of a health care service pursuant to the provisions of this title, provided, however, that any determination rendered concerning such denial pursuant to existing federal and state law relating to the Medicare or Medicaid program or pursuant to federal law enacted subsequent to the effective date of this title and providing for an external appeal process for such denials shall be binding on the

enrollee and the insurer and shall supersede any determinations rendered pursuant to this title.

§ 4911. Powers of the commissioner. 1. The commissioner shall have the power to grant and revoke certifications of external appeal agents to conduct external appeals requested pursuant to either paragraph (a) or (b) of subdivision two of section forty-nine hundred ten of this title or pursuant to both such paragraphs.

2. If, after reviewing the application authorized by section forty-nine hundred twelve of this title, the commissioner is satisfied that the applicant meets the requirements of this section, the commissioner shall issue a certificate to the applicant. A certificate issued under this section shall be valid for a period of not more than two years.

3. In order to be re-certified, an external appeal agent must demonstrate to the commissioner on forms prescribed by the commissioner that it continues to meet all applicable standards required by this title. Re-certification under this section shall be valid for a period of not more than two years.

§ 4912. Standards for certification. 1. The commissioner shall develop an application for certification. At a minimum, applicants shall provide:

(a) a description of the qualifications of the clinical peer reviewers retained to conduct external appeals of final adverse determinations, including such reviewers' current and past employment history and practice affiliations;

(b) a description of the procedures employed to ensure that clinical peer reviewers conducting external appeals are:

(i) appropriately licensed, registered or certified;

(ii) trained in the principles, procedures and standards of the external appeal agent; and

(iii) knowledgeable about the health care service which is the subject

of the final adverse determination under appeal;

(c) a description of the methods of recruiting and selecting impartial clinical peer reviewers and matching such reviewers to specific cases;

(d) the number of clinical peer reviewers retained by the external appeal agent, and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review;

(e) a description of the policies and procedures employed to protect the confidentiality of individual medical and treatment records in accordance with applicable state and federal laws;

(f) a description of the quality assurance program established by the external appeal agent pursuant to paragraph (c) of subdivision two of this section;

(g) the names of all corporations and organizations owned or controlled by the external appeal agent or which owns or controls such agent, and the nature and extent of any such ownership or control;

(h) the names and biographies of all directors, officers, and executives of the external appeal agent;

(i) an experimental and investigational treatment review plan to conduct appeals pursuant to subparagraph (B) of paragraph (d) of subdivision two of section forty-nine hundred fourteen of this title; and

(j) a description of the fees to be charged by agents for external appeals.

2. The commissioner shall, at a minimum, require an external appeal agent to:

(a) appoint a medical director, who is a physician in possession of a current and valid non-restricted license to practice medicine. Such director shall be responsible for the supervision and oversight of the external appeal process;

(b) develop written policies and procedures governing all aspects of the appeal process, including, at a minimum:

(i) procedures to ensure that appeals are conducted within the time frames specified in section forty-nine hundred fourteen of this title, and any required notices are provided in a timely manner;

(ii) procedures to ensure the selection of qualified and impartial

clinical peer reviewers. Such reviewers shall be qualified to render determinations relating to the health care service which is the subject of the final adverse determination under appeal;

(iii) procedures to ensure the confidentiality of medical and treatment records and review materials; and

(iv) procedures to ensure adherence to the requirements of this title by any contractor, subcontractor, subvendor, agent or employee affiliated by contract or otherwise with such external appeal agent;

(c) establish a quality assurance program. Such program shall include written descriptions, to be provided to all individuals involved in such program, of the organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in external appeals performed by the external appeal agent and to ensure the maintenance of program standards pursuant to this section;

(d) establish a toll-free telephone service to receive information on a 24-hour-a-day 7-day-a-week basis relating to external appeals pursuant to this title. Such system shall be capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours;

(e) develop procedures to ensure that:

(i) appropriate personnel are reasonably accessible not less than forty hours per week during normal business hours to discuss patient care and to allow response to telephone requests, and

(ii) response to accepted or recorded messages shall be made not less than one business day after the date on which the call was received; and

(f) be accredited by a nationally recognized private accrediting organization.

3. No entity shall be qualified to submit such request for application if it owns or controls, is owned or controlled by, or exercises common control with, any of the following:

(a) any national, state or local illness, health benefit or public advocacy group;

(b) any national, state or local society or association of hospitals, physicians, or other providers of health care services; or

(c) any national, state or local association of health care plans.

4. A health care plan shall transmit, and an external appeal agent shall be authorized to receive and review, an enrollee's medical and treatment records in order to conduct an external appeal pursuant to this title.

5. An external appeal agent shall provide ready access to the commissioner to all data, records, and information collected and maintained concerning such agent's external appeal activities.

6. An external appeal agent shall agree to provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the external appeal process established pursuant to this title.

7. The commissioner shall provide, upon the request of any interested person, a copy of all non-proprietary information filed with the commissioner by the external appeal agent. The commissioner may charge a reasonable fee to the interested person for reproducing the requested information.

§ 4913. Conflict of interest. 1. No external appeal agent or officer, director, or management employee thereof; or clinical peer reviewer employed or engaged thereby to conduct any external appeal pursuant to this title, shall have any material professional affiliation, material familial affiliation, material financial affiliation, or other affiliation prescribed pursuant to regulation, with any of the following:

(a) the health care plan;

(b) any officer, director, or management employee of the health care plan;

(c) any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable medical equipment, proposing to provide or supply the health service;

(d) the facility at which the health service would be provided;

(e) the developer or manufacturer of the principal health service which is the subject of the appeal; or

(f) the enrollee whose health care service is the subject of the appeal, or the enrollee's designee.

2. Notwithstanding the provisions of subdivision one of this section, the commissioner shall promulgate regulations to minimize any conflict of interest where such conflict may be unavoidable.

§ 4914. Procedures for external appeals of adverse determinations. 1. The commissioner shall establish procedures by regulation to randomly assign an external appeal agent to conduct an external appeal, provided that the commissioner may establish a maximum fee which may be charged for any such external appeal, or the commissioner may exclude from such random assignment any external appeal agent which charges a fee which she deems to be unreasonable.

2. (a) The enrollee shall have four months to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, or after the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19. Where applicable, the enrollee's health care provider shall have sixty days to initiate an external appeal after the enrollee or the enrollee's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such

documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

(b) The external appeal agent shall make a determination with respect to the appeal within thirty days of the receipt of the request therefor, submitted in accordance with the commissioner's instructions. The external appeal agent shall have the opportunity to request additional information from the enrollee, the enrollee's health care provider and the enrollee's health care plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the enrollee, the enrollee's health care provider where appropriate, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, if the enrollee's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the enrollee, or if the enrollee is entitled to an expedited external appeal pursuant to section 2719 of the federal Public Health Service Act, 42 U.S.C. § 300gg-19, the external appeal shall be completed within no more than seventy-two hours of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the enrollee, the enrollee's health care provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

(d) (A) For external appeals requested pursuant to paragraph (a) of subdivision two of section forty-nine hundred ten of this title, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient. When the external appeal agent makes its determination, it shall consider the clinical standards of the plan, the

information provided concerning the patient, the attending physician's recommendation, and applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations. Provided that such determination shall:

- (i) be conducted only by one or a greater odd number of clinical peer reviewers,

- (ii) be accompanied by a notice of appeal determination which shall include the reasons for the determination; provided, however, that where the final adverse determination is upheld on appeal, the notice shall include the clinical rationale, if any, for such determination,

- (iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

- (iv) be binding on the plan and the enrollee, and

- (v) be admissible in any court proceeding.

(B) For external appeals requested pursuant to paragraph (b) of subdivision two of section forty-nine hundred ten of this title, the external appeal agent shall review the proposed health service or procedure for which coverage has been denied and, in accordance with the provisions of this title and the external agent's experimental and investigational treatment review plan, make a determination as to whether the patient costs of such health service or procedure shall be covered by the health care plan; provided that such determination shall:

- (i) be conducted by a panel of three or a greater odd number of clinical peer reviewers,

- (ii) be accompanied by a written statement:

- (1) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, based upon review of the applicable medical and scientific evidence and, in connection with rare diseases, the physician's certification required by subdivision seven-g of section forty-nine hundred of this article and such other evidence as the enrollee, the enrollee's designee or the enrollee's attending physician may present (or upon confirmation that the recommended treatment is a clinical trial), the enrollee's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of

paragraph (b) of subdivision five of section forty-nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the enrollee's condition or disease or, for rare diseases, that the requested health service or procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure (or, in the case of a clinical trial, is likely to benefit the enrollee in the treatment of the enrollee's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

(2) upholding the health plan's denial of coverage,

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,

(iv) be binding on the plan and the enrollee, and

(v) be admissible in any court proceeding.

As used in this subparagraph (B) with respect to a clinical trial, patient costs shall include all costs of health services required to provide treatment to the enrollee according to the design of the trial. Such costs shall not include the costs of any investigational drugs or devices themselves, the cost of any nonhealth services that might be required for the enrollee to receive the treatment, the costs of managing the research, or costs which would not be covered under the policy for noninvestigational treatments.

(C) For external appeals requested pursuant to paragraph (c) of subdivision two of section four thousand nine hundred ten of this title relating to an out-of-network denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network health service shall be covered by the health plan.

(i) The external appeal agent shall assign one clinical peer reviewer to make a determination as to whether the out-of-network health service is materially different from the health service available in-network.

(ii) If a determination is made that the out-of-network health service is not materially different from the health service available in-network the out-of-network health service shall not be covered by the health

plan.

(iii) If a determination is made that the out-of-network health service is materially different from the health service available in-network, the external appeal agent shall assign a panel with an additional two or a greater odd number of clinical peer reviewers which shall make a determination as to whether the out-of-network health service shall be covered by the health plan; provided that such determination shall:

(1) be accompanied by a written statement that:

(I) the out-of-network health service shall be covered by the health care plan either: when a majority of the panel of reviewers determines, upon review of the health service requested by the enrollee, the alternate recommended health service proposed by the plan, the clinical standards of the plan, the information provided concerning the enrollee, the attending physician's recommendation, the applicable medical and scientific evidence, the enrollee's medical record, and any other pertinent information that the out-of-network health service is likely to be more clinically beneficial than the proposed in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the in-network health service; or

(II) uphold the health plan's denial of coverage.

(2) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(3) be binding on the plan and the enrollee; and

(4) be admissible in any court proceeding.

(D) For external appeals requested pursuant to paragraph (d) of subdivision two of section four thousand nine hundred ten of this title relating to an out-of-network referral denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network referral shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

(1) that the out-of-network referral shall be covered by the health

care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the enrollee, the attending physician's recommendation, the enrollee's medical record, and any other pertinent information, that the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an enrollee who is able to provide the requested health service, and that the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an enrollee, is able to provide the requested health service, and is likely to produce a more clinically beneficial outcome; or

(2) upholding the health plan's denial of coverage;

(iii) be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

(iv) be binding on the plan and the enrollee; and

(v) be admissible in any court proceeding.

3. No external appeal agent or clinical peer reviewer conducting an external appeal shall be liable in damages to any person for any opinions rendered by such external appeal agent or clinical peer reviewer upon completion of an external appeal conducted pursuant to this section, unless such opinion was rendered in bad faith or involved gross negligence.

4. (a) Except as provided in paragraphs (b) and (c) of this subdivision, payment for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days from the date the appeal determination is received by the health care plan, and the health care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date

the bill was required to be paid, in the event that payment is not made within such forty-five days.

(b) If an enrollee's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in whole, payment for the external appeal shall be made by the health care provider in the manner and subject to the timeframes and requirements set forth in paragraph (a) of this subdivision.

(c) If an enrollee's health care provider requests an external appeal of a concurrent adverse determination and the external appeal agent upholds the health care plan's determination in part, payment for the external appeal shall be evenly divided between the health care plan and the enrollee's health care provider who requested the external appeal and shall be made by the health care plan and the enrollee's health care provider in the manner and subject to the timeframes and requirements set forth in paragraph (a) of this subdivision; provided, however, that the commissioner may, upon a determination by the superintendent of financial services that health care plans or health care providers are experiencing a substantial hardship as a result of payment for the external appeal when the external appeal agent upholds the health care plan's determination in part, in consultation with the superintendent, promulgate regulations to limit such hardship.

(d) If an enrollee's health care provider was acting as the enrollee's designee, payment for the external appeal shall be made by the health care plan. The external appeal and any designation shall be submitted on a standard form developed by the commissioner in consultation with the superintendent of financial services pursuant to subdivision five of this section. The superintendent of financial services shall have the authority upon receipt of an external appeal to confirm the designation or request other information as necessary, in which case the superintendent of financial services shall make at least two written requests to the enrollee to confirm the designation. The enrollee shall have two weeks to respond to each such request. If the enrollee fails to respond to the superintendent of financial services within the specified timeframe, the superintendent of financial services shall make two written requests to the health care provider to file an external appeal on his or her own behalf. The health care provider shall have two weeks

to respond to each such request. If the health care provider does not respond to the superintendent of financial services requests within the specified timeframe, the superintendent of financial services shall reject the appeal. If the health care provider responds to the superintendent's requests, payment for the external appeal shall be made in accordance with paragraphs (b) and (c) of this subdivision.

5. The commissioner, in consultation with the superintendent of financial services, shall promulgate by regulation a standard description of the external appeal process established under this section, which shall provide a standard form and instructions for the initiation of an external appeal by an enrollee.

§ 4915. Prohibited practices. An external appeal agent shall not, with respect to external appeal activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

1. either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

2. any other method that encourages the upholding of an adverse determination.

§ 4916. Oversight and surveillance of the external appeal process. 1. The commissioner shall have the power to:

(a) review the activities of the health care plans and external appeal agents pursuant to this title, including the extent to which such plans and agents adhere to the standards and time frames required pursuant to this title;

(b) investigate complaints by enrollees regarding requests for and processing of external appeals; and

(c) conduct random audits of health care plans and external appeal agents to determine compliance with the provisions of this title.

2. Each health care plan and external appeal agent shall annually, in such form as the commissioner shall require, report the number of external appeals requested by enrollees and the outcomes of any such external appeals.

3. The commissioner shall annually report, by plan and agent, such information to the governor and the legislature, provided that no such information shall be included which would otherwise be deemed confidential information within the meaning of this chapter.

§ 4917. Hold harmless. A health care provider requesting an external appeal of a concurrent adverse determination, including when the health care provider requests an external appeal as the enrollee's designee, shall not pursue reimbursement from the enrollee for services determined not medically necessary by the external appeal agent, except to collect a copayment.

ARTICLE 49-A

MEDICAL DEBT REPORTING

Section 4925. Definitions.

4926. Medical debt reporting prohibited in contracts with collection entities.

4927. Enforcement.

§ 4925. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Medical debt" means an obligation or alleged obligation of a consumer to pay any amount whatsoever related to the receipt of health care services, products, or devices provided to a person by a hospital licensed under article twenty-eight of this chapter, a health care professional authorized under title eight of the education law or an ambulance service certified under article thirty of this chapter. Medical debt does not include debt charged to a credit card unless the

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

2. "Collection entity" means any individual, partnership, corporation, trust, estate, co-operative, association, government or government subdivision, agency or other entity that either purchases medical debt or collects medical debt on behalf of another entity.

3. "Consumer reporting agency" shall have the same meaning as such term is defined in section three hundred eighty-a of the general business law.

§ 4926. Medical debt reporting prohibited in contracts with collection entities. A hospital licensed under article twenty-eight of this chapter, a health care professional authorized under title eight of the education law, or an ambulance service certified under article thirty of this chapter:

1. shall not furnish any portion of a medical debt to a consumer reporting agency; and

2. shall include a provision in any contract entered into with a collection entity for the purchase or collection of medical debt that prohibits the reporting of any portion of such medical debt to a consumer reporting agency.

§ 4927. Enforcement. Any portion of a medical debt that is furnished to a consumer reporting agency shall be void.

ARTICLE 50

SEPARABILITY CLAUSE; SAVING CLAUSE; CONSTRUCTION; LAWS REPEALED; TIME OF TAKING EFFECT

Section 5000. Separability clause.

5001. Saving clause; construction.

5002. Laws repealed.

5003. Time of taking effect.

§ 5000. Separability clause. If any clause, sentence, paragraph, section or part of this chapter shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section, or part thereof directly involved in the controversy in which such judgment shall have been rendered.

§ 5001. Saving clause; construction. 1. Nothing contained in this act shall affect or impair any act done or right accruing, accrued or acquired, or any penalty, forfeiture or punishment incurred prior to the time when this act shall take effect, under or by virtue of the provision or provisions of the public health law, as in force immediately prior to the time this act shall take effect, but the same may be asserted, enforced, prosecuted or inflicted, as fully and to the same extent as if this act shall not have taken effect.

2. An act of the legislature of the year nineteen hundred fifty-four which adds or purports to add a new article, section, subdivision or other provision of law to the public health law, as in force immediately prior to the time this act shall take effect, shall be deemed and construed as having been added to such law, as amended by this act, and shall be given full effect according to its context as if the same had been added expressly and in terms of such law, as amended by this act, and shall be deemed and construed to have been inserted in such law, as amended by this act, in the appropriate respective position in regard to and as modifying the effect of the corresponding provision or provisions of such law, as amended by this act.

3. Reference in any act of the legislature of the year nineteen hundred fifty-four to an existing article, section, subdivision or other

provision of the public health law, as in force immediately prior to the time this act shall take effect, shall be deemed and construed to refer to the corresponding article, section, subdivision or other provision of such law, as renumbered, modified or amended by this act.

4. Reference in any general, special or local law, rule, regulation or public document to any provision or provisions of the public health law, as in force immediately prior to the time this act shall take effect, shall be deemed to be and construed as a reference to the corresponding provision or provisions of such law, as renumbered, modified or amended by this act, irrespective of whether such provision or provisions is or are contained in one or more than one title, article, section, subdivision or other part thereof.

5. The provisions of this chapter in so far as they are substantially the same as the existing provisions of the public health law shall be construed as a continuation of the provisions of the former public health law and not as new enactments.

6. This chapter shall not affect pending actions or proceedings, civil or criminal, but the same may be prosecuted or defended in the same manner and with the same effect as though this chapter had not been passed.

§ 5002. Laws repealed. Chapter forty-nine of the laws of nineteen hundred nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws, " and all acts amendatory thereof and supplemental thereto, constituting the public health law as heretofore in force, are hereby repealed, except as otherwise provided herein.

§ 5003. Time of taking effect. This act shall take effect June first, nineteen hundred fifty-four.